A REVIEW OF THE
COORDINATED HOME CARE PROGRAM

FOR

ALBERTA SOCIAL SERVICES
AND COMMUNITY HEALTH

MARCH, 1983

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March 18, 1983

Mr. Ken Lederer
Chairman, Steering Committee
Coordinated Home Care Program Review Project
c/o Planning Secretariat
Alberta Social Services & Community Health
Centre West
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Edmonton, Alberta
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Dear Mr. Lederer:

We are pleased to present ten copies of our final report on the review of the Coordinated Home Care Program conducted by our firm. The study has been challenging, particularly in view of its scope and broad coverage of the province. It has also been satisfying because of the support and interest shown by all the participants, including the members of your Steering Committee.

We believe that our final report presents, in a fair and representative way, the broad views of the many individuals and organizations who participated in the study. These views should be of value to Alberta Social Services and Community Health and should contribute to refinements and further development of the Coordinated Home Care Program in the province.

It has been a pleasure to work with your Committee and to place our resources at the service of this study.

Yours truly,

RMC RESOURCES MANAGEMENT CONSULTANTS
(ALBERTA) LTD.

M.B. Kohut
Senior Principal

MBK:bm

EXECUTIVE SUMMARY

BACKGROUND TO THE STUDY

The Coordinated Home Care Program was introduced by the Alberta Government in 1978 through the Department of Social Services and Community Health. Its essential purpose is to provide medical and support services to Albertans in the home. One of the objectives of the program was "to determine the extent to which Coordinated Home Care Program objectives are being met". To achieve this evaluative end, the Department has undertaken several studies of the Coordinated Home Care Program. One of these was a review of the program, the subject of this report. This study was undertaken by RMC Resources Management Consultants (Alberta) Ltd. on September 28, 1982, under contract to the Minister of Social Services and Community Health. A Steering Committee provided support and guidance to the study team conducting the review.

The major objectives of this study were:

1. to assess how well the program is doing;
2. to identify its strengths and weaknesses;
3. to determine the involvement of the program in the process of assessing and placing persons in extended care institutions; and,
4. to describe rural-urban differences on how the program is viewed.

STUDY METHODS

The review was structured to allow input from the widest possible range of associations, organizations, agencies and individuals. The intention was to conduct an "interpretive" rather than technically rigorous study. This involved:

- interviews with local program personnel, including Board members;
- interviews with clients of the program and a review of letters submitted by clients and/or family members;

- reviews of written submission from agencies, institutions, and individuals;
- public meetings throughout Alberta; and,
- telephone interviews with members of Assessment and Placement Committees of Nursing Home and Auxiliary Hospital Districts.

MAJOR FINDINGS

The Coordinated Home Care Program is generally perceived to be a successful, positive contribution to the health care system of Alberta, and of valuable assistance to its recipients locally. The MAJOR ACHIEVEMENTS identified by respondents were that the program:

* permits people, particularly the elderly, to remain in their own homes or lodges;
* prevents or reduces institutionalization; and,
* facilitates early discharge from hospitals and thereby frees acute care beds for more needy patients.

Program STRENGTHS contributing to these achievements were:

* the commitment, caring and other positive qualities of program staff;
* the multidisciplinary team approach to delivery of care; and,
* a program orientation to client control, independence and choice.

The level of satisfaction with the program was high. The achievements and strengths of the program appeared to be held with great intensity. Nevertheless, weaknesses were noted. These seemed to be presented by the respondents in the spirit of helping to make a good program better.

The major WEAKNESSES identified were:

* Insufficient Funding:

  The inability to meet existing service requirements and an inability to accommodate growth and expansion were commonly noted.

- * Restricted Entry Criteria:

  The lack of a social entry (non-medical entry) was perceived to be a major restriction to the provision of necessary care.

- * Limited Physician Involvement:

  Physicians were reluctant to refer patients to the program, either because they were unaware of the Coordinated Home Care Program, because of the extra efforts they faced to admit patients to the program compared to placing them elsewhere, and/or because they were not remunerated for their involvement in the program.

In addition to these major strengths and weaknesses, a number of KEY ISSUES were identified. These were:

Comprehensive Assessment

Support for a non-medical entry often was accompanied by a discussion of the need for comprehensive (medical/ functional/social) assessments by professionals to determine service needs of clients. The lack of such assessments was seen to be a weakness.

Scope of Program Services

An expansion of services was commonly suggested. Specialized "medical", as well as mental health, and "social" services were recommended by various respondents. Certain programs/ services were not consistently available throughout the province.

Service Gaps

Rural and remote areas were perceived to have less accessibility to programs. Service gaps were attributed to:

- budget constraints;
- shortages and the distribution of certain personnel (e.g., rehabilitation professionals);
- limited public and physician awareness of the program;
- lack of access to the program by those not meeting entry criteria, particularly many of the frail elderly, those with degenerative illnesses, and the handicapped; and,

- the unavailability of approved programs or limitations in the delivery of services (respite care, palliative care, nutritional counselling, and limited hours of service).

Fees

Confusion was found to exist over the different fee scales for support services charged by the Coordinated Home Care Program and Family and Community Support Services. On the issue of whether fees should be charged at all, there was no consensus.

Administration and Control

The paperwork required for documenting cases, administering the program, and reporting to the provincial Home Care Unit was felt to be an unreasonable burden by many respondents. The program was seen to be "top heavy" in management by a small number of respondents, who held this view strongly.

Coordination/Fragmentation

Coordination of services was identified as an achievement and a program strength in interviews with many program personnel. However, the issue of fragmentation of services, and the need for better coordination was raised in many briefs and at public meetings, particularly in urban areas. Some coordination difficulties existed at the local level between the Coordinated Home Care Program and both the provider agencies and hospitals. The need for greater coordination was called for at the provincial level between Social Services and Community Health and Hospitals and Medical Care.

The Role of the Coordinated Home Care Program in the Health Care System

Concern was raised that the program is "peripheral" to the predominant institutional sector, and that it is not accepted as a true alternative to institutionalization by the Alberta health care system. Suggestions were made to shift resources from Alberta Hospitals and Medical Care to the community health sector, and to make the Coordinated Home Care Program the entry point into the institutional long term care sector.

OTHER FINDINGS

Based on telephone interviews with institutional Assessment and Placement Committee members, it appears that the Coordinated Home Care Program is not represented on nineteen of thirty-two Committees. According to nearly one quarter of the respondents, the program was not considered to be an alternative to institutional placement, mainly because of the level of care required by prospective clients. However, waiting lists were thought to be decreased as a result of the availability of home care by twenty of the respondents.

Although the views expressed on the program varied across the province consensus was clear on three points: that the main purpose of the program was to keep people in their homes; that funding was the greatest concern; and, that staff and their qualities were held in high esteem. The need for a non-medical/social entry appeared to be of somewhat greater importance for urban areas, than rural areas or those with regional urban centres surrounded by rural areas ("mixed" areas). Interagency coordination problems and the lack of incentives for clients to use the program were uniquely urban concerns. Reluctance by physicians to refer to the program, fee schedule problems, and complaints regarding inordinate paperwork, were more common to the mixed areas. Rural groups expressed special concern over the lack of access to services in remote areas and the lack of rehabilitation and support services. Promotion of independence and improvements in quality of life tended to be emphasized as special program achievements more by rural respondents than by others. Satisfaction with the program was high in all locations.

ACKNOWLEDGEMENTS

A large number of individuals and organizations participated in the Coordinated Home Care Program Review. Their contributions are gratefully acknowledged, as is the patience, perseverance, and good humour extended to the project team throughout its travels. Board members, Home Care Management Committee members and the staff of the 26 Local Health Authorities visited by the project team provided candid comments on the program in 220 interviews. Home care clients and their families not only sent in 67 letters offering comments on the program, but also willingly gave of their time, and in most cases opened their homes to project team members, for some 115 interviews. Over 220 members of the general public and service delivery staff participated in 13 public meetings held across Alberta. Eighty-five submissions in the form of briefs and letters were received from individuals (not home care clients) and organizations, many of them clearly the result of considerable thought, time and effort. Senior representatives of nine key organizations met with a project team member for special interviews. Finally, 32 Assessment and Placement Committee members of Auxiliary Hospital and Nursing Home Districts contributed their views. To each participant, the project team offers its thanks. An abbreviated list of participants may be found in Appendix C.

Special acknowledgment is also given to members of the Steering Committee (both those serving to the end of the study and one who left before the end due to a reassignment) for providing critical logistical support. The Committee also offered valuable guidance which helped to clarify the draft report. While RMC recognizes the Steering Committee's contribution, we also accept that its members may or may not share the views, in whole or in part, expressed by this report.

The RMC Resources Management Consultants (Alberta) Ltd. project team conducting this study comprised Vangie Kelpin, Myroslaw Kohut (Project Director), Lynne Mansell, Mary Lou Marino, Anne Morrison and Muriel Roggensack. Peter Marshall provided computer programming and analysis support.

Typing and production assistance were provided by Barbara Marsh and Lorraine Parsons.

NOTES TO READERS

This report comprises seven chapters and a set of appendices. Following the Introduction and Background provided in Chapter 1, Chapter 2 provides a Summary of Major Findings. Each chapter which follows provides information on views obtained from different sources: Chapter 3, from Home Care Program Interviews; Chapter 4, Client Interviews and Letters; Chapter 5, Submissions from Individuals (non-clients) and Organizations, Institutions, and Groups; Chapter 6, Public Meetings; and Chapter 7, Assessment and Placement Committee Member Interviews. The appendices include the questionnaires, a list of most common responses, an abbreviated list of respondents, and the Home Care Regulations for reference.

This report was designed to serve a number of different audiences:

* For senior executives in the Department of Social Services and Community Health and the general public, the Executive Summary, and Chapter 2: Summary of Major Findings, will be of primary interest. A review of Chapter 1 (possibly excluding the detailed methodology of sections 1.5.1-1.5.5) would also be helpful.

* For Coordinated Home Care Program development staff, the comments in Chapters 3 through 7 will provide rich detail on views held across the province.

* For organizations designated for special interviews, and for those interested in their input, Chapter 5 provides substantial detail.

* Comments from interviewees found throughout the body of the report, particularly in Chapter 3, Home Care Program and Chapter 4, Clients, are illustrative of the feelings held on the program. These may be of interest to all readers.

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CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE REVIEW

1.1 CHAPTER OVERVIEW

The purpose of this chapter is to introduce and lay a framework for the entire report. Included is a brief discussion on each of the following:

* the structure, philosophy and objectives of the current Coordinated Home Care Program;
* the background to the study;
* the terms of reference of the review; and,
* methods of data collection and analysis, and limitations.

1.2 PROGRAM DESCRIPTION

1.2.1 Program Structure

The Coordinated Home Care Program was introduced by the Alberta government in March 1978 on a province-wide basis so that Albertans could receive medical and support services while living at home. The program is funded by the Department of Social Services and Community Health, and operated at the community level through twenty-six Local Health Authorities. Responsibility for directing the program rests with the Local Health Authority Board and the Director/Medical Officer of Health. The program is administered by a Home Care Coordinator. In each local program, a Home Care Management Committee (with a maximum of ten members) functions in an advisory capacity and reports to the Local Health Authority Board.

1.2.2 Program Philosophy

The philosophy of the Coordinated Home Care Program which follows was prepared jointly by the Local Health Authorities and the Home Care Unit, (formerly known as the Home Care Directorate) of Alberta Social Services and Community Health.

A statement of program philosophy is a statement of beliefs which provides guidance for staff in achieving the objectives of the Program. For the Coordinated Home Care Program, the statement of philosophy finds its roots in the Ministerial Statement on Home Care, delivered by the Honorable Helen Hunley in March, 1978 and in the statement of philosophy and purpose for community health services (January, 1980). The statement of philosophy, the Home Care Regulations, and the goals of the Program are mutually consistent. Any statement of philosophy adopted by a local health authority must be compatible with these provincial statements.

The Home Care Unit, together with local Coordinated Home Care Programs, believe that:

1. Home Care, while accepting that health is a community concern, must encourage the individual to take responsibility for maintaining his/her health.

2. The preferred method of delivering Home Care services is on a decentralized basis, through the Local Health Authorities.

3. Home Care is an integral component in any comprehensive health care delivery system.

4. Home Care should be available to persons throughout the Province for whom this is the most appropriate health care mode.

5. Home Care services must enhance the existing resources of the client, family, and community to enable them to achieve and/or maintain optimal level of functioning.

6. The multi-disciplinary health care team approach, which emphasizes the role of the client and family in care planning is the appropriate method of providing home care services to the client.

7. In providing services to clients, it is essential that the local Coordinated Home Care Program coordinate the activities of Home Care staff, in order that they are integrated with other workers and volunteer groups in the community.

1.2.3 Program Objectives

The objectives of the Coordinated Home Care Program as prepared by the Home Care Unit, Alberta Social Services and Community Health in 1978 are:

1. To coordinate the provision of Home Care services to persons meeting the admission criteria, particularly the elderly and adult handicapped in order to:
   a) improve, maintain or retard deterioration of health status and level of independence
   b) reduce admissions to health care institutions
   c) facilitate early discharge of patients in health care institutions thereby reducing their length of stay;
2. To develop, maintain and upgrade standards of care so that Home Care services are provided in an efficient, effective and humane manner;
3. To make available throughout the province all the services listed in the Home Care Regulation, Section 2 (3) and (4), so as to meet the needs of potential Home Care recipients;
4. To increase the capacity of families and other social networks to provide care for persons in need;
5. To promote cooperation among health and social service agencies in the community so that:
   a) services for Home Care recipients and referrals by the Home Care program to other agencies are effective, efficient, and timely and
   b) community services are not unnecessarily duplicated;
6. To involve volunteers in the provision of Home Care services;
7. To advise decision makers on program changes needed to meet the needs of client groups; and
8. To determine the extent to which Coordinated Home Care Program objectives are being met.

1.2.4 Program Regulations

The Home Care Regulations governing the implementation and operation of the Coordinated Home Care Program may be found in Appendix A. Of most interest to this study, the specific regulations concerning the eligibility for admission of individuals to the program, the scope of services, and the payment of user fees.

The following criteria determine eligibility for admission to the Coordinated Home Care Program:

* The client must require one or more of the following "medical" services: Home Nursing, Physiotherapy, Occupational Therapy, Respiratory Therapy or Speech Therapy;

* The client and family must want the service to be provided in their home;

* The home must be an appropriate setting so that care can be given in a safe and effective manner;

* The client must be an Alberta resident and have a health care insurance number;

* The client must be under the care of a physician who corroborates the need for the above "medical" services.

Persons assessed as requiring support services, but not a "medical" service, are not eligible for admission to Home Care.

The scope of services provided by local home care programs vary from area to area, depending upon the size of the program, the availability of specialized personnel, and the distances involved. However, the Regulations stipulate that each program must include Home Nursing services and Homemaker services. Optional services include Occupational Therapy, Physiotherapy, Respiratory Therapy, dressings, drugs, the use of specialized medical equipment, handyman services, meals-on-wheels, and transportation.

Services in the medical category are provided to users without charge. Support services are provided without charge for the first two weeks that a person receives services, following which a user fee may be levied using a sliding scale, depending on monthly income.

1.3 BACKGROUND TO THE STUDY

One of the original objectives of the Coordinated Home Care Program, as described in section 1.2, was to determine the extent to which the program objectives are being met. The major purpose of this review is to assist in the achievement of that objective. The review is one of a series of assignments undertaken by Alberta Social Services and Community Health to document and assess program operations, utilization, costs and general benefits.

This study is not intended to be analytic or technically rigorous (i.e. it is not a formal program evaluation). Rather, it is a review whose purpose is to seek out and report on the general opinions of a broad range of publics regarding the question HOW WELL IS THE COORDINATED HOME CARE PROGRAM DOING AFTER FOUR YEARS OF IMPLEMENTATION?

The study was designed to achieve broad representation and input from a variety of sources:

> "home care management committees; local health authority boards and other health unit staff, Victorian Order of Nurses; Alberta Association of Registered Nurses; Alberta Medical Association, as well as other health professional associations. Input will be requested from the Provincial Senior Citizens Advisory Council and the Alberta Council on Aging on utilization of services. Families and individuals (such as on waiting lists for nursing homes, and auxiliary hospitals) will have the oportunity to participate. The approach taken will be open to input from any other association, organization, agency or individual who chooses to provide their views."
>
> (Armit letter, August 18, 1982)

It was subsequently determined by the Steering Committee that input would also be sought from the Health Unit Association of Alberta, the Alberta Association of Homemaker Services, the Alberta Hospital Association and Assocation of the Nursing Home Review Panel, as represented by its former Chairman.

To focus application of project team efforts toward the review and opinion gathering purpose of the study, the consulting team was directed to concentrate on "seeking opinions". Utilization reviews, analysis of program costs, detailed reviews of background information (including literature reviews), comparative analyses with other jurisdictions, and the presentation of recommendations were not part of the study. (Gardner letter, September 24, 1982). It is anticipated that the results of this review will be integrated with other studies conducted by Alberta Social Services and Community Health. Thus, the review constitutes a means to an end rather than an end in itself.

This study was commissioned by the Minister of Alberta Social Services and Community Health. A selection committee, chaired by Janet Howell, Acting Executive Director, Planning Secretariat, received proposals, conducted interviews and subsequently selected RMC Resources Management Consultants (Alberta) Ltd. to carry out the assignment. The study was commenced on September 28, 1982.

1.4 TERMS OF REFERENCE OF THE REVIEW

The terms of reference for the Review are contained in the August 18, 1982 letter from Amelita A. Armit to Mr. Myroslaw Kohut, Senior Principal, RMC Resources Management Consultants (Alberta) Ltd.; the RMC proposal dated August 29, 1982; and an amending letter confirming required changes to the proposal, from Dr. Leslie Gardner, Planning Secretariat to Mr. Kohut, dated September 24, 1982.

The basic objectives of the study were to:

"1. identify the achievements and strengths of the program.

2. indicate issues, concerns, and limitations with the delivery of the program and the services of the program; and proposed solutions.

3. determine the views particularly of families and individuals (such as on waiting lists for nursing homes and auxiliary hospitals) as to the factors leading to institutionalization; and how and the extent to which the Alberta Coordinated Home Care Program could address these factors.

4. describe the rural-urban differences as they relate to 1 to 3 above."

(Armit letter, August 18, 1982)

A Steering Committee was appointed to guide and administer the study. Committee members reviewed and approved all questionnaires and the location of public meetings. In addition, they assisted with the logistics of informing groups about the study, and they reviewed the working and final drafts of this report. The members were:

Dr. Leslie Gardner	Chairperson to November 15, 1982, Planning Secretariat
Mr. Ken Lederer	Chairperson from mid-November to the completion of the study, Planning Secretariat
Ms. Carol Blair	Wetoka Health Unit
Dr. Ken Hodgins	Sturgeon Health Unit
Ms. Jean Schmidt	Home Care Unit, Alberta Social Services and Community Health

Mr. Ray LaFleur, who joined the Planning Secretariat about the time of the submission of the working draft report, contributed to the reviews of draft documentation.

1.5 DATA COLLECTION AND ANALYSIS

1.5.1 Summary

The methods used for data collection and analysis were based on the "opinion seeking" requirements of the study. The approach had two major components: seeking out the views of designated groups and individuals, and presenting opportunities for others to contribute their views.

The review consisted of:

- visits to all 26 health units in the province offering a Coordinated Home Care Program;
- interviews and letters from clients and family members;
- letters and briefs submitted from individuals, organizations, and groups;
- public meetings across the province; and,
- interviews with members of Assessment and Placement Committees

The data was obtained and compiled using an open-ended questionnaire format in order to allow the widest possible range of issues and comments to surface (See Appendix B for the complete set of questionnaires). The data was analyzed by sorting and summarizing participant responses manually and with the assistance of a computer.

1.5.2 Home Care Program Interviews

A total of 220 interviews were held with a representative(s) of the following respondent categories:

- Local Health Authority Boards;
- Medical Officers of Health, Medical Consultants, Local Health Authority Directors;
- Home Care Management Committees;
- Home Care Coordinators, Directors, Area Coordinators, Supervisors;
- Nursing Service Providers, Rehabilitative Service Providers; and,
- Support Service Providers, Homemaker (or Family and Community Social Services) Supervisors.

For the purpose of data analysis, each interview was coded according to Local Health Authority, respondent category and location (rural, urban, mixed). Rural units were identified as those which did not contain a major urban centre; urban units were those which were entirely or primarily urban in nature; and, mixed units were those which contained an urban centre in addition to a large rural component. (See Appendix C.1).

No attempt was made during the analysis to weight interviews or responses to questions according to the number of persons who attended each interview. More than one interview per respondent category was often conducted in each Local Health Authority.

All 220 interviews were analyzed to produce a preliminary list of the most frequently mentioned responses for each of the questions (See Appendix D). This list was then used to code each response. Codes were also assigned to location and respondent categories. A computer program was developed to sort the data as required and produce the following reports:

- Provincial Summary of Question Responses;
- Question Responses by Location; and
- Question Responses by Respondent Category.

1.5.3 Clients and Family Members

Data were collected from individual clients and/or family members in two ways: personal interviews and letters received by the project team.

Interviews were held with clients during visits to the twenty-six Local Health Authorities. Clients were selected through the random generation of twenty client identification numbers for each Local Health Authority by the Home Care Unit, Alberta Social Services and Community Health. The Home Care Coordinator for each local program then identified the selected individuals, and provided additional information regarding their capability and/or availability to be interviewed. Certain prospective interviewees were eliminated from the original set of clients by project team members for the following reasons: death, hospitalization, extreme confusion or lack of communication skills, remote location, or upon physician request. However, some non-English (Ukrainian) speaking clients and many clients outside the main office location remaining on the lists were interviewed.

The selection of specific clients to be interviewed was done by project team members. In the case of large urban programs, additional identification numbers were selected and the corresponding clients were interviewed by telephone. In Local Health Authorities which had a consent policy for research projects, a member of the Home Care Program staff contacted the clients to obtain permission for an interview and to arrange an appropriate time.

Most interviews were conducted in the client's home or Senior Citizens' Lodge; although a few clients were interviewed at the Local Health Authority office, in hospital, or by telephone. Often, the client's spouse or other family members were present. Clients were informed that all comments would be confidential.

The client interviews were analyzed manually according to client characteristics (location, sex, length of time on program) and major types of responses, supplemented by direct quotations.

Clients or family members submitted comments about the Coordinated Home Care Program in the form of letters, if they were unable to attend the public meeting in their area. (The invitations for submissions were published in the media as part of the advertising for local public meetings).

As in the case of client interviews, the client letters were analyzed according to client characteristics (location, sex, length of time on the program), and types of comments. Where possible, these comments were summarized according to the interview questionnaire to facilitate comparability.

1.5.4 Submissions

Data were collected for this component of the study in the following ways:

- Interviews with senior representatives of key associations designated by the Steering Committee. Most of these interviews were supplemented by written briefs.
- Briefs submitted in response to a general request for briefs sent to associations and agencies designated by the Steering Committee.
- Briefs submitted voluntarily by groups or individuals who learned of the review via the media or word of mouth.

For a list of associations, groups, and individuals who submitted briefs, see Appendix C.2.

Each submission, and/or set of interview notes, was analyzed and presented in summary form. Since the majority of those who submitted briefs responded selectively to the questionnaire provided to them, trends were not always evident. The summaries are therefore often more selective than representative.

1.5.5 Public Meetings

It was decided by the Steering Committee that a total of 14 public meetings (7 in urban centres, and 7 in rural centres) would be held for the review - distributed as evenly as possible throughout Alberta. Since the Home Care Management Committee of the Calgary Health Services Home Care Program had already planned a large Workshop to review their own program, the project team excluded Calgary from its original list. A member of the project team did, however, attend the Calgary Workshop.

Home Care Coordinators assisted project team members in arranging meeting dates, times, locations and advertising. Local, weekly and daily newspapers, notice boards, and public service radio and television announcements were the primary vehicles for informing interested members of the public about the meetings. Since funds for public meeting expenses were limited, newspaper advertisements were normally displayed once or twice before each meeting.

A "hand-out" was distributed at each meeting containing a brief list of open-ended questions for use as a guide during discussions. One or two project team members led each discussion and recorded issues and comments in written form or on tape.

Since the number and affiliation of persons attending each meeting varied greatly, the method of analysis selected was to describe the general nature or tone of each meeting and the issues discussed, along with selected direct quotations.

1.5.6 Assessment and Placement Committee Interviews

To estimate the impact of the Coordinated Home Care Program on the institutionalization of Alberta residents in long term care facilities, telephone interviews were held with members of local Assessment and Placement Committees for District Auxiliary Hospitals and Nursing Homes. Such committees are required by Alberta Hospitals and Medical Care and are attached to District Boards. Nursing homes under private ownership were not contacted.

Assessment and Placement Committee representatives were asked whether a home care representative was on the Committee, whether Home Care was considered as an alternative for placement, and whether, in their view, the Coordinated Home Care Program had affected their institution's waiting list.

For the purpose of analysis, positive or negative responses to each question were summarized, illustrated by additional comments.

This approach represented a departure from the original terms of reference, which was to seek out views of individuals on waiting lists for extended care institutions (or their families), and to identify the factors leading to institutionalization. The departure became necessary when it was determined that seeking out such views would be of little value unless the project team were to review patient assessments and the professional judgements associated with them. This was clearly beyond the scope of the study.

1.5.7 Limitations

While the broad geographic coverage of the study and the quantity of data collected provides a credible base for policy development and further study, the research and its potential uses has certain limitations. The most important of these are:

* Since the review was specifically intended to provide opportunities for various publics to express their viewpoints, it is essentially "impressionistic", and does not qualify as a program evaluation.

* The wide variation in the nature and size of attendance at public meetings limits the degree to which the results can be generalized to the residents of a specific area or compared with other areas.

* The client sample is neither large enough nor proportionate enough to the caseload of each Local Health Authority to permit generalizing the results to all Coordinated Home Care Program clients in Alberta.

* A bias may exist toward the viewpoints of individuals who were more readily accessible by the project team (i.e., there was inadequate representation from some remote, possibly underserviced, areas).

- The classification of Local Health Authorities as rural, urban, or mixed was arbitrary and should not imply that these categories are entirely homogeneous or mutually exclusive.

- The views of physicians may not be adequately represented since only a small number of individual physicians were interviewed or submitted briefs.

- The advertising budget for public meetings and submission of letters and briefs was limited. While considerable use was made of free community service advertising mechanisms, there were likely individuals whose opportunity to contribute to the study may have been limited by lack of information about it.

- The time frame of the review was restrictive, particularly for the preparation of briefs.

CHAPTER 2: SUMMARY OF MAJOR FINDINGS

2.1 CHAPTER OVERVIEW

Chapter 2 focusses on the major findings of the review of the Coordinated Home Care Program. Consequently, its contents address the question HOW WELL IS THE HOME CARE PROGRAM DOING AFTER FOUR YEARS OF IMPLEMENTATION?

The chapter also:

- reports on issues, concerns, and limitations of the Coordinated Home Care Program;
- addresses current issues associated with Assessment and Placement in long term care institutions; and
- summarizes differing perceptions of the program in rural and urban areas.

2.2 MAJOR FINDINGS

The primary finding is that the Coordinated Home Care Program is perceived to be a successful, positive contribution to the health care system of Alberta generally, and of valuable assistance to its recipients locally. Support for the program was expressed by all categories of respondents. The satisfaction level of clients is best expressed in their own words:

> "Without Home Care, I would be dead...Home Care kept me alive."
>
> "I feel the best I have in three years. I'm even driving my car again. And a lot of it has to do with Home Care."
>
> "I think it's fantastic. For the first time since the accident (in which I was injured and lost my sight), everything's starting to come together."

The satisfaction level also extended to providers. One major provider offered the following enthusiastic view in a brief:

> "It [the Coordinated Home Care Program] has become a reality! It is fantastic! The Provincial Government should be highly commended for its inception of the provincially funded Coordinated Home Care Program."

Only four respondents out of the nearly 500 interviewed, or from whom letters or briefs were received, were distinctly non-supportive to the program. Only one individual at a public meeting expressed views that could be interpreted as being against the program.

The major achievements identified by respondents were that the program:

- permits people, particularly the elderly, to remain in their own home or lodges;
- prevents or reduces institutionalization;
- facilitates early discharge from hospitals thereby freeing acute beds for more needy patients;
- satisfies client and community needs for care; and
- provides expanded access to rehabilitation and support services in communities.

Program strengths contributing to these achievements were found to be:

- the positive qualities of home care staff (including contracted staff); in particular, their commitment to service and sense of caring;
- the multidisciplinary, team approach to providing care;
- the client control orientation of the program, and its role in enhancing client independence;
- the coordinating capability of home care to bring together various resources (including those from provider agencies) and to apply them to the care of the client; and,
- the local community based authority for delivering the program.

Weaknesses in the program were noted by all respondents; however, associations and groups were generally more critical than clients. This was not surprising, since the associations typically were concerned not only with identifying deficiencies in the current program, but also were interested in having the program evolve to their respective visions of what it should be. Generally, more weaknesses than strengths were noted in the study as a whole. This likely occurred for at least three reasons:

1. Respondents frequently associated program achievements with purposes and strengths.

2. Weaknesses were more readily identified by respondents, particularly since they knew the program was being "reviewed".

3. Respondents typically wished to be helpful to the program; identifying weaknesses appeared to be a way to contribute information that could initiate change, thereby helping to make a good program better.

Commonly identified weaknesses were:

* Insufficient Funding:

  This was the most frequent weakness noted. Respondents indicated an inability to meet existing service requirements and an inability to accommodate growth and expansion in the program.

* Restricted Entry Criteria:

  The second most common weakness was the restriction of entry to the program through the use of medical criteria, or as many respondents noted, the lack of a "social" entry.

* Limited Physician Involvement:

  Physicians were reluctant to refer patients to the program, either because they were unaware of the Coordinated Home Care Program, because of the extra efforts they faced to admit patients to the program, compared to placing them elsewhere, and/or because they were not remunerated for their involvement in the program.

The achievements, strengths, and weaknesses identified by respondents help to form a perspective on the Coordinated Home Care Program as a whole. This perspective may be briefly compared to the philosophy and objectives of the program (see Sections 1.2.2 and 1.2.3). For example, five of the seven philosophical principles of the program are directly related to study findings on major achievements and strengths:

* DECENTRALIZED SERVICE DELIVERY exists by virtue of program delivery through the Local Authorities of Health. The local focus for delivery was seen as one of the five major strengths of the program. (Principle 2, p2).

* AVAILABILITY OF HOME CARE THROUGHOUT THE PROVINCE generally exists. The fourth most frequently noted achievement was that the program satisfied client and community needs, demonstrating its availability. (Principle 4, p2).

* PROGRAM ENHANCEMENT OF EXISTING RESOURCES also occurs. Three major achievements of the program were allowing people to remain at home, preventing institutionalization and permitting more effective use of acute care beds through early discharges to home care. Through home care therefore, family and client resources (the home), and community resources (hospital beds) were seen to be more effectively utilized. (Principle 5, p2).

* A MULTIDISCIPLINARY HEALTH CARE TEAM approach is the preferred means of delivering care. This was the second most common program strength identified. (Principle 6, p2).

* COORDINATION is a key philosophical principle. It was also seen as a major program strength. (Principle 7, p2)

Two other philosophical principles are less obviously linked to the results of this review. The principle of ENCOURAGING INDIVIDUAL RESPONSIBILITY FOR MAINTAINING HIS/HER HEALTH (Principle 1, p2), is only weakly reflected in study results. INTEGRATION OF HOME CARE INTO THE COMPREHENSIVE HEALTH CARE SYSTEM (Principle 3, p2). has an even more tenuous relationship to the findings, particularly when the major weaknesses (lack of social entry, limited physician involvement) are considered, or when the issue of the role of home care in the Alberta health care system is examined. On the whole, however, the Coordinated Home Care Program does appear to be evolving within the philosophic premises governing its service delivery.

Although a brief comparison of key findings does suggest a positive correlation between the views of the respondents and the programs philosophy and objectives, a closer examination indicates some difficulties. For example, while services are delivered on a decentralized basis, conflict exists as a result of the requirements for local autonomy/responsibility and central control and administration. The Health Unit Association of Alberta and the Alberta Association of Registered Nurses made recommendations to eliminate from the Regulations references to the Management Committee, position titles etc. Inclusion of these items in the Regulations places them under central control, thereby limiting local authority and responsibility. This was perceived as program centralization rather than decentralization by many respondents. Growing administrative burdens (identified as a major weakness) related to reporting and operating requirements of the Home Care Unit, Alberta Social Services and Community Health, are also indicators of centralization.

Other findings that suggest limitations to the degree that the program meets its philosophy and objective statements are:

* Availability of services is limited in remote and some rural areas. (It is also limited to only those who meet entry criteria). Natives with treaty status, new arrivals from other provinces, the RMCP and some others have no access to the Coordinated Home Care Program. (Principle 4, p2).

* Existing local resources are not always "enhanced" by the program. The Victorian Order of Nurses and the Alberta Association of Homemaker Services expressed concern over attitudes by program staff leading to more recruiting of Local Health Authority staff versus contracting with existing resources and services. (Principle 6, p2).

* The Victorian Order of Nurses and one hospital specifically expressed concern over the "erosion" of the role of the voluntary sector - a concern perceived to be relevant to the program objective regarding volunteers in home care delivery. (Objective 6, p3).

* The multidisciplinary team approach needs strengthening through a greater involvement of physicians in the home care process, (beginning with greater numbers of referrals). (Principle 6, p2).

Comparison between the objectives (section 1.2.3) and the key findings on achievements and strengths in this study also suggests a position correlation. Other information obtained by Alberta Social Services and Community Health from previous studies may add to the results of this study to contribute to a clearer assessment of the degree to which the philosophy and program objectives are being met.

2.3 ISSUES AND CONCERNS

In addition to the major strengths and weaknesses of the previous section, a number of key issues were identified in the study. These were:

Comprehensive Assessment

Support for a non-medical entry often was accompanied by a discussion of the need for comprehensive (medical/functional/social) assessments by professionals to determine service needs of clients. The lack of such assessments was also seen to be a weakness.

Scope of Program Services

An expansion of services was commonly suggested. Specialized "medical", as well as mental health, and "social" services were recommended by various respondents. Certain programs/services were not consistently available throughout the province, for example, home care was not available to clients living in some lodges.

Service Gaps

Rural and remote areas were generally perceived to have less accessibility to programs. Service gaps were attributed to:

- budget constraints;
- shortages and the distribution of certain personnel (e.g., rehabilitation professionals);
- limited public and physician awareness of the program;
- lack of access to the program by those not meeting entry criteria, particularly many of the frail elderly, those with degenerative illnesses, and the handicapped; and,
- the unavailability of approved programs or limitations in the delivery of services (respite care, palliative care, nutritional counselling, and limited hours of service).

Fees

Confusion was found to exist over the different fee scales for support services charged by the Coordinated Home Care Program and Family and Community Support Services. On the issue of whether fees should be charged at all, there was no consensus.

Administration and Controls

The paperwork required for documenting cases, administering the program, and reporting to the provincial Home Care Unit was felt to be an unreasonable burden by many respondents. The program was seen to be "top heavy" in management by a small number of respondents, who held this view strongly.

Coordination/Fragmentation

Coordination of services was identified as an achievement and a program strength in interviews with many program personnel. However, the issue of fragmentation of services, and the need for better coordination was raised in many briefs and at public meetings, particularly in urban areas. Some coordination difficulties existed at the local level between the Coordinated Home Care Program and both provider agencies and hospitals. The need for greater coordination was called for at the provincial level between Social Services and Community Health and Hospitals and Medical Care.

The Role of the Coordinated Home Care Program in the Health Care System

Concern was raised that the program is "peripheral" to the predominant institutional sector, and that it is not accepted as a true alternative to institutionalization by the Alberta health care system. Suggestions were made to shift resources from Alberta Hospitals and Medical Care to the community health sector, and to make the Coordinated Home Care Program the entry point into the institutional long term care sector.

2.4 ASSESSMENT AND PLACEMENT AND THE COORDINATED HOME CARE PROGRAM

The involvement of the Coordinated Home Care Program with institutional assessment and placement committees was reviewed by the study. According to telephone interviews with Committee members, representation from the Coordinated Home Care Program apparently does not exist on nineteen of the thirty-two Committees. The program was not considered to be an alternative to institutional placement by nearly one quarter of the respondents, mainly because of the level of care required by prospective clients. Waiting lists were thought to be decreased as a result of the availability of home care by twenty of the thirty-two respondents.

2.5 RURAL- URBAN DIFFERENCES

Although views expressed on the program varied across the province, consensus was clear on three points: that the main purpose of the program was to keep people in their homes; that funding was the greatest concern; and, that staff and their qualities were held in high esteem. The need for non-medical/social entry appeared to be of somewhat greater importance for urban areas, than rural areas or those with regional urban centres surrounded by rural areas ("mixed" areas). Interagency coordination problems and lack of incentives for clients to use the program were uniquely urban concerns. Reluctance by physicians to refer to the program, fee schedule problems, and complaints regarding inordinate paperwork were more common to the mixed areas.

Rural groups expressed special concern over the lack of access to services in remote areas and the lack of rehabilitation and support services. Promotion of independence and improvements in quality of life tended to be emphasized as special program achievements more by rural respondents than by others. Satisfaction with the program was high in all locations.

2.6 CONCLUDING OBSERVATIONS

In summary, the study found that the Coordinated Home Care Program has STRONG SUPPORT among the publics sought out by this review, and appears to be delivering services reasonably consistent with its stated philosophy and objectives. The weaknesses, gaps in services, and issues identified by respondents do not detract from the support the program enjoys. Rather, they appear to have been presented in order to facilitate change and future program development. Two respondents characterized the program and its current stage of development by the following answers to the question HOW WELL IS THE HOME CARE PROGRAM DOING AFTER FOUR YEARS OF IMPLEMENTATION?

> "The program is doing well for a four year old, but it still has a way to grow."
>
> "It has matured sufficiently to warrant change."

CHAPTER 3: COORDINATED HOME CARE PROGRAM INTERVIEWS

3.1 CHAPTER OVERVIEW

The purpose of this chapter is to summarize the viewpoints of a range of respondents directly associated with the Home Care Programs in 26 Local Health Authorities. A provincial summary of responses is provided, followed by an analysis by Local Health Authority location (rural, urban, mixed) and respondent category.

Table 3.1 illustrates the distribution of the 220 interviews held during the review by location and by respondent category.

TABLE 3.1

HOME CARE PROGRAM INTERVIEWS BY TYPE

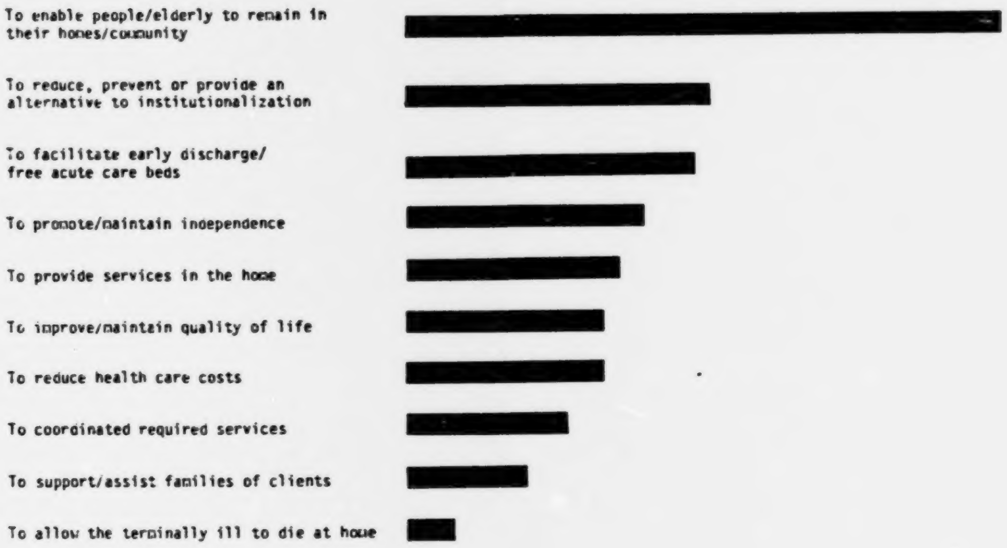
Respondent Category	Location Urban	 Rural	 Mixed	Total	% Total Interviews
1. Local Health Authority Board	4	17	5	26	(11.8)
2. Medical Officers of Health, Medical Consultants, Health Unit Directors	4	20	5	29	(13.2)
3. Home Care Management/Advisory Committees	4	17	7	28	(12.7)
4. Home Care Directors, Coordinators, Area Coordinators, Supervisors	10	23	9	42	(19.1)
5. Nursing and Rehabilitative Service Providers	8	37	11	56	(25.5)
6. Support Services Providers, Homemaker Supervisors, FCSS Supervisors	4	16	8	28	(12.7)
7. Others (Lodge Matrons, Physician, Volunteer Coord.)	3	4	4	11	(5.0)
Total	37	134	49	220	(100.0)
% Total Interviews	16.8%	60.9%	22.3%	100.0%	

3.2 PROVINCIAL SUMMARY

On the following pages are eight bar charts illustrating findings from field interviews with persons involved with the Coordinated Home Care Program. These charts are intended to help the reader to compare the most common responses rather than to indicate absolute numbers of responses. Although the charts are self explanatory, some brief commentary is also provided.

FIGURE 3.1

Relative Frequency of Response: What is the PURPOSE of the Coordinated Home Care Program?



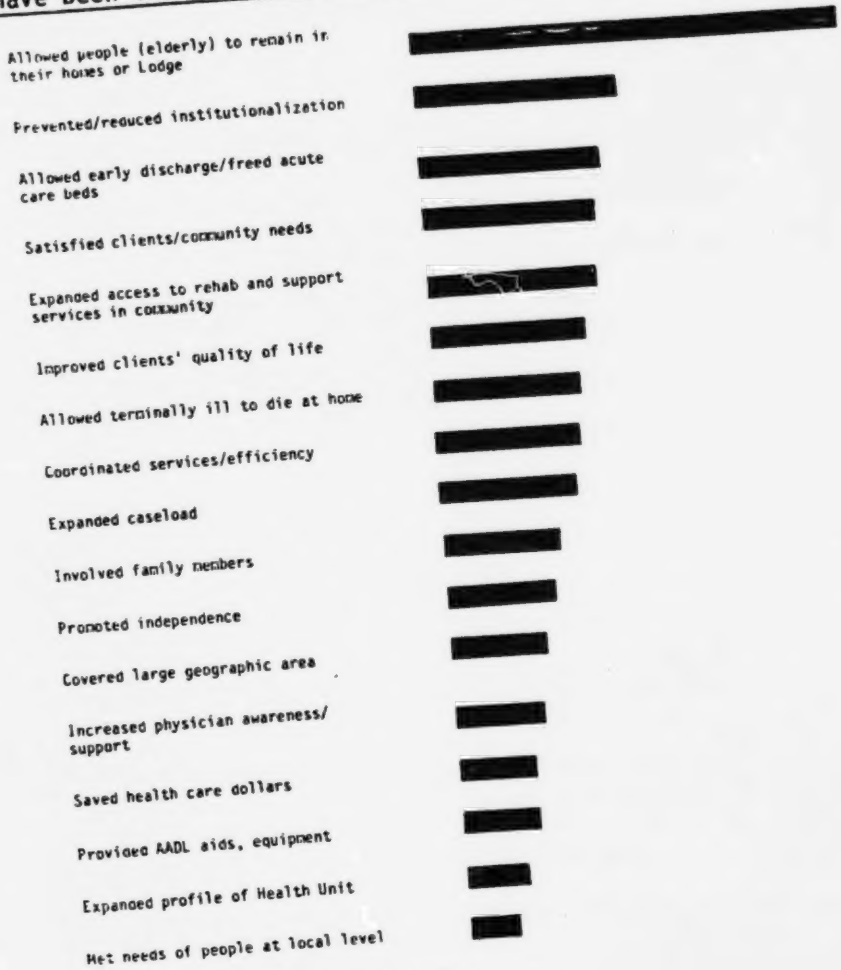
Enabling people to remain in their homes and minimizing institutionalization were clearly seen as fundamental purposes of the program.

When the findings in the chart are compared with the stated objectives of the Program (see Section 1.2.3), a great deal of common understanding is evident. The following Program Objectives appear to be well accepted in the field:

- improve...level of independence;
- reduce admissions to health care institutions;
- facilitate early discharge of patients in health care institutions;
- increase the capacity of families...to provide care for persons in need; and
- promote cooperation among health and social agencies.

FIGURE 3.2

Relative Frequency of Response:
What have been the ACHIEVEMENTS of the Coordinated Home Care Program?

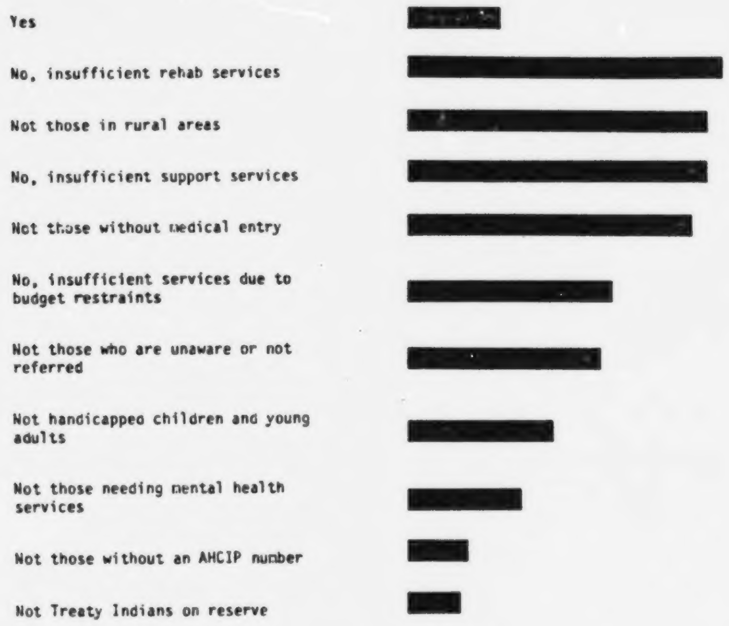


Note: AADL - Alberta Aids to Daily Living

As indicated in Figure 3.2, people associated with the Coordinated Home Care Program believed it was achieving its major purposes, i.e., to enable people to remain in their homes and/or to reduce institutionalization and encourage early discharge from hospital. Also frequently mentioned was the simple fact that the program had met a community need and that clients were satisfied with the services provided. The fifth most frequently mentioned achievement was that the program had provided or expanded access to rehabilitation and support services that did not exist previously. Numerous other accomplishments were mentioned, as the reader can see from Figure 3.2.

FIGURE 3.3

Relative Frequency of Response:
Are PEOPLE RECEIVING the SERVICES they need from Home Care?



Note: AHCIP - Alberta Health Care Insurance Plan

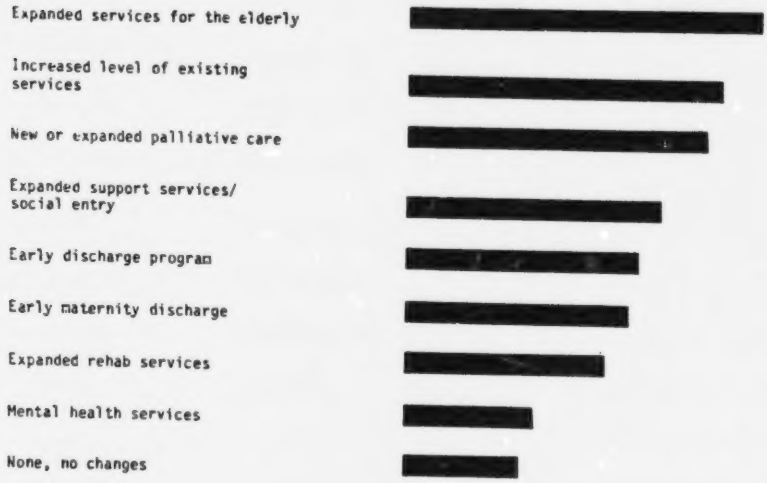
Figure 3.3 shows respondents felt that gaps in services exist. These gaps tended to fall into two categories, one being groups of people who are not receiving needed services, and the other being services which are inadequately provided.

The two major groups of people whom respondents perceived to be inadequately served were those residing in rural or remote locations and those without medical entry, such as a the frail elderly, handicapped children and adults, and persons with needs for mental health services.

Two major categories of service gaps were identified by respondents. Most frequently mentioned was lack of or inadequate rehabilitation services, such as physiotherapy, occupational therapy, speech therapy, and podiatry. The second most frequently mentioned service gap was inadequate support services, due to lack of Family & Community Support Services programs in some areas of the province or lack of financial and other resources to develop and deliver support services.

FIGURE 3.4

Relative Frequency of Response:
What special service NEEDS might arise in the FUTURE?

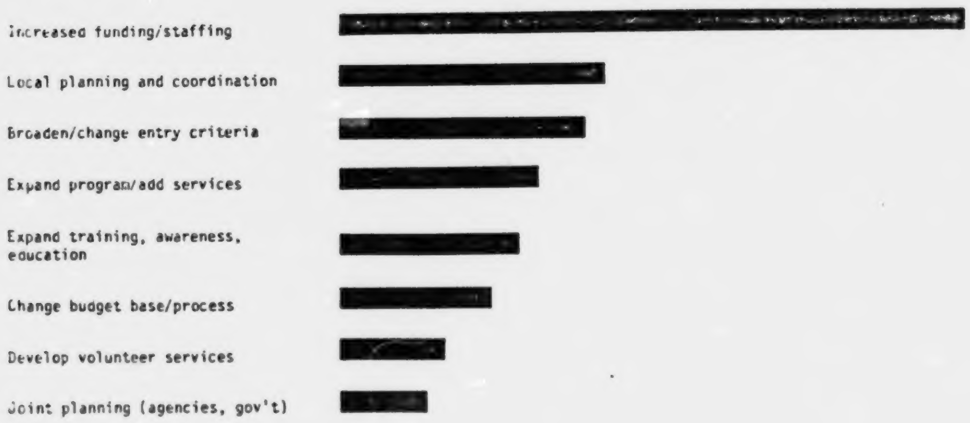


Expanded services for the elderly was the most frequently mentioned future need. This reflected a concern over the ever-increasing population of seniors and the impact this will have on demand for services.

The second most frequently mentioned future service need was increasing level of existing services, arising from such factors as increased public and physician awareness, increasing population in general, and increasing pressure on hospital bed utilization. Many respondents felt that there will be future requirements for developing or expanding special programs such as palliative care, early discharge from hospital or early maternity discharge, for reasons similar to those above - public awareness and pressure on hospitals.

FIGURE 3.5

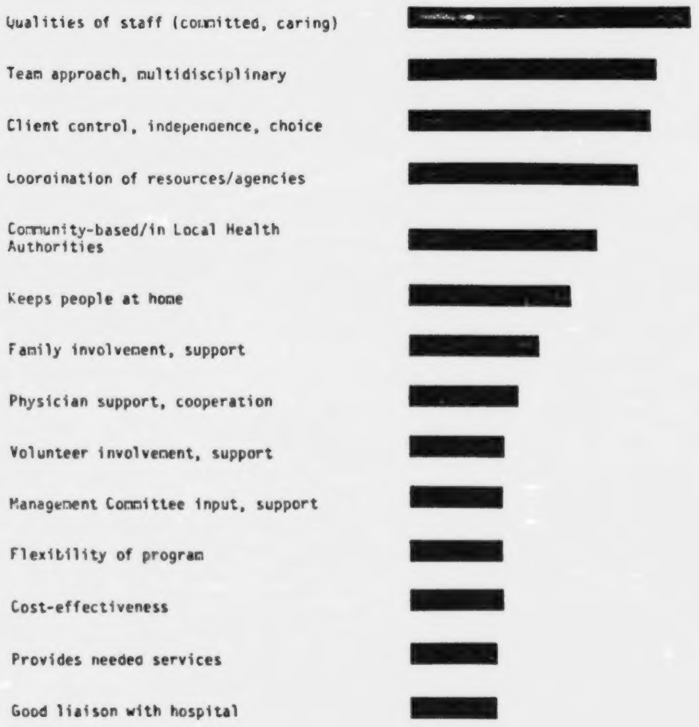
Relative Frequency of Response:
How should the Coordinated Home Care Program RESPOND TO FUTURE NEEDS?



The foremost response was a call for increased funding and staffing to meet the future increased demand for services. Respondents offered other suggestions for meeting the future demand, such as local planning, coordination and development of resources and broadening the entry criteria.

FIGURE 3.6

Relative Frequency of Response:
What are the greatest STRENGTHS of the Coordinated Home Care Program?

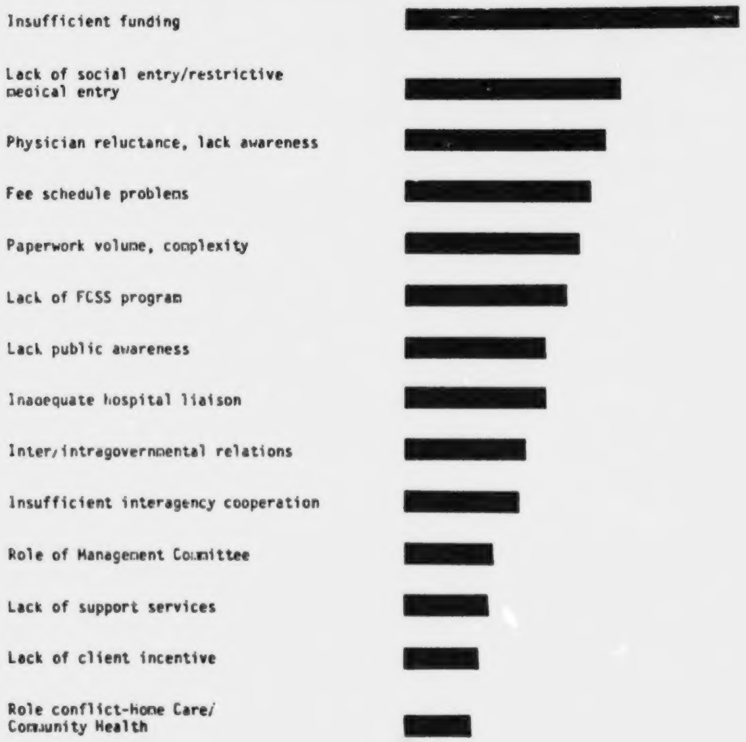


The program was perceived to have a variety of strengths. Most frequently commented upon were qualities of staff, such as commitment, caring attitude and professional responsibility, followed closely by the strength of a team or multidisciplinary approach to service delivery. Another strength of the program was that it deals with clients on a one-to-one basis, thus contributing to client independence.

Coordination of local services and agencies and the program's community base within the Local Health Authority structure were frequently said to be strengths, as was the involvement of family, physicians, and volunteers in the delivery of care. The contribution of Home Care Management Committees in providing "grass roots" input was also seen as a strength. This group of responses seems to reflect the view that local control and the involvement of local people in the planning and delivery of care are desirable attributes of the program.

FIGURE 3.7

Relative Frequency of Response:
What are the greatest WEAKNESSES of the Coordinated Home Care Program?

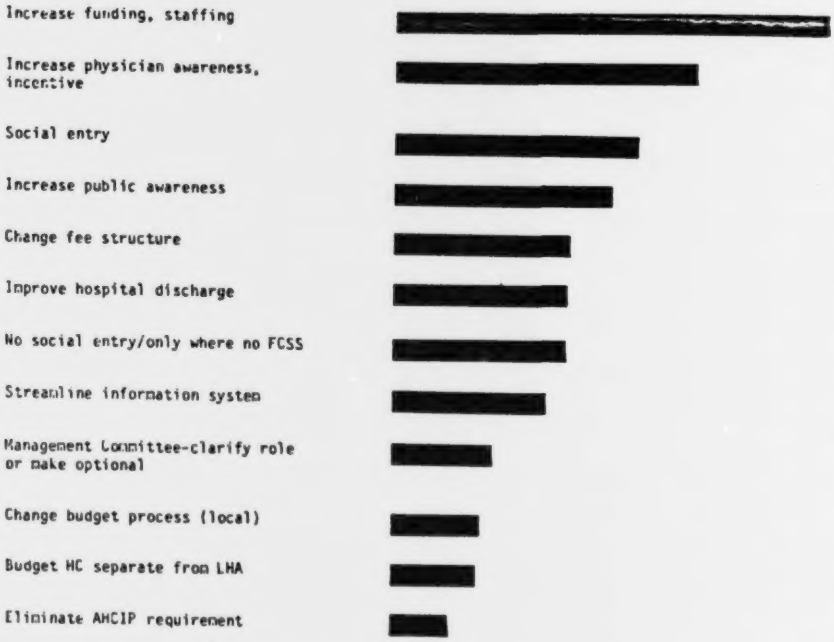


Note: FCSS - Family and Community Support Services

Insufficient funding was considered to be the greatest weakness of the current program. A wide variety of other specific weaknesses were cited with relatively equal frequency, such as restrictiveness of the medical entry criterion, weaknesses in relationships with physicians, fee schedule problems and paperwork.

FIGURE 3.8

Relative Frequency of Response:
How could the Weaknesses be REMEDIED?



Note: FCSS - Family and Community Support Services
HC - Home Care
LHA - Local Health Authority
AHCIP - Alberta Health Care Insurance Plan

In general, remedies paralleled weaknesses. Thus, increased funding and staffing were called for most frequently. Improvements in relationships with the public, physicians, hospitals, and other agencies were also frequently cited. A social entry into the program was also viewed as desirable.

3.3 ANALYSIS OF HOME CARE PROGRAM INTERVIEWS BY LOCATION

TABLE 3.2

ANALYSIS OF HOME CARE PROGRAM INTERVIEWS BY LOCATION - A COMPARATIVE SUMMARY

QUESTION CATEGORY	RURAL	URBAN	MIXED
PURPOSE	To keep people at home	To keep people at home	To keep people at home
ACHIEVEMENTS	People kept at home	Freed acute care beds. People kept in homes	People kept at home
SERVICE GAPS	Insufficient Rehabilitation Services	No social entry	Inadequate rural access
FUTURE NEEDS	Expanded services to elderly	Expanded palliative care	Increased overall service level. Expanded services to elderly
RESPONSE TO FUTURE NEEDS	Increased funding/ staffing	Increased funding/ staffing	Increased funding/ staffing
MAJOR STRENTHS	Staff qualities Team approach Client control	Coordination Client control Staff qualities	Coordination Team approach Staff qualities
MAJOR WEAKNESSES	Insufficient funding. No social entry. Insufficient physician referrals	Insufficient funding. No social entry	Insufficient funding. Fee schedule issues
REMEDIES to WEAKNESSES	Increased funding/ staffing. Increased physician awareness. Utilization incentives for physicians.	Increased funding/ staffing	Increased funding/ staffing

The major similarities and differences in responses are summarized by location in Table 3.2. The table is highlighted and amplified below:

* There was consensus among urban, rural, and mixed groups that the major PURPOSE of the program was to keep people at home, followed by reducing institutionalization and freeing acute care beds. Urban respondents also emphasized promoting independence; urban and mixed groups together emphasized reducing health care costs.

* A large number of equally important ACHIEVEMENTS were cited. All groups agreed that the program has enabled people to remain in their homes, with the urban group placing an equal emphasis on the achievement of freeing acute care beds.

* Other differences in ACHIEVEMENTS were the ranking of perceived client/community satisfaction higher for rural and mixed groups than for urban; and the greater emphasis within the rural group on coverage of a large geographic area, promotion of independence, and improved client quality of life.

* Urban, rural, and mixed groups showed marked differences in opinion regarding SERVICE GAPS. Rural and mixed groups emphasized insufficient rehabilitative services and support services along with a lack of access to Home Care in outlying areas. In contast, urban respondents pointed to a lack of access by people without a medical entry and without a referral, as well as by handicapped children and young adults. Other urban issues concerned the inability to provide an adequate level of service overall due to the budget constraints, as well as the inability to provide service to clients lacking an AHCIP number.

* Responses of the three groups to FUTURE NEEDS were similar in nature but differed in priority. The rural group most frequently mentioned the need for expanded services for the elderly; the mixed group was more concerned with increasing the level of existing services; and the urban group showed a fairly strong preference for expansion of palliative care. Other differences included less emphasis on early discharge programs in rural and mixed areas, and less emphasis on mental health services in urban areas.

* There was strong consensus that the best RESPONSE to FUTURE NEEDS was increased funding and staffing of local Home Care programs, along with overall expansion of services. Local planning and coordination, and broadening or changing entry criteria were also mentioned frequently with slightly more emphasis on changing entry criteria by the rural group.

* The location of respondents appeared to have little effect on the relative importance of the STRENGTHS of the Coordinated Home Care Program. Staff qualities, team approach, client control or independence, and the establishment of the program within Local Health Authorities were emphasized by all three groups. One difference in emphasis was that coordination of resources and agencies was mentioned most frequently by urban and mixed groups. The support provided by the Home Care Management Committee was cited most often as a strength by the mixed group respondents.

TABLE 3.3

ANALYSIS OF HOME CARE PROGRAM INTERVIEWS BY RESPONDENT CATEGORY: COMPARATIVE SUMMARY OF MOST FREQUENT RESPONSE

QUESTION	LHA BOARDS	MOH/DIRECTORS	HC MANAGEMENT COMMITTEE	HC COORDINATORS/ SUPERVISORS	NURSING/REHAB. PROVIDERS	SUPPORT SERVICE PROVIDERS	OTHER
PURPOSE	To keep people at home	To reduce/prevent institutionalization	To keep people at home	To keep people at home	To keep people at home	To keep people at home	To keep people at home
ACHIEVEMENTS	People kept at home	People kept at home	People kept at home	People kept at home	People kept at home	People kept at home	People kept at home
SERVICE GAPS	Inadequate rural access	No social entry	Inadequate rural access	Inadequate rehab. services. Inadequate support services	Inadequate rehab. services	Inadequate rural access. People are not aware/ not referred	None (services OK) Those without ACHIP. Inadequate rehab. services
FUTURE NEEDS	Increased overall service level	Expanded services for the elderly. Early maternity discharge	Increased overall service level	New/expanded palliative care	Expanded services to elderly	Expanded support services	Expanded services to elderly
RESPONSE TO FUTURE NEEDS	Increased funding/staffing	Increased funding/staffing	Increased funding/staffing	Increased funding/staffing	Increased funding/staffing	Increased funding/staffing	Increased funding/staffing
MAJOR STRENGTHS	Staff qualities	Community based	Staff qualities	Staff qualities	Coordination of services	Staff qualities	Coordination of services
MAJOR WEAKNESSES	Insufficient funding	Insufficient funding	Insufficient funding	Insufficient funding	Insufficient funding	Lack of social entry	Insufficient funding
REMEDIES	Increased funding/staffing	Increased physician awareness. Utilization incentives for physicians	Increased physician awareness. Utilization incentives for physicians	Increased funding/staffing	Increased funding/staffing	Increased funding/staffing. Social entry	Increased funding/staffing

* There was consensus among rural, urban and mixed resondents that the major WEAKNESS of the program was insufficient funding. Inter- and intragovernmental relationships were cited by urban and mixed respondents but almost never mentioned by those in rural areas. Insufficient interagency cooperation and a lack of incentive for prospective clients to utilize home care appeared to be uniquely urban concerns. A much greater emphasis was placed upon the lack of social entry by both the rural and urban groups than by the mixed group. The reluctance of physicians to refer to the program, fee schedule problems, and paperwork complaints were commented upon more frequently by the mixed group. Lack of Family & Community Support Services programs was perceived to have a negative influence on rural and some mixed Home Care programs.

* Suggestions for REMEDIES to weaknesses were similar, with the major remedy being increased funding and staffing, followed by increased physician awareness and/or incentives. The implementation of "social entry" was most frequently suggested by the urban group, with many rural and mixed respondents cautioning against full social entry.

3.4 VIEWPOINTS BY RESPONDENT CATEGORY

Table 3.3 summarizes the most frequent responses in each respondent group. Some highlights of the table are:

* All respondent groups cited "to keep people at home" as the major PURPOSE of the program, with the exception of Medical Officers and Directors who emphasized the reduction or prevention of institutionalization.

* All felt that keeping people in their homes was the major ACHIEVEMENT of the program.

* According to Boards, Management Committees and Support Service providers, the major SERVICE GAP was lack of access to services by rural residents. Medical Officers and Directors most frequently mentioned lack of access by those without a medical entry. Nursing and Rehabilitation Service providers emphasized lack of rehabilitation and/or support services.

- The most common FUTURE NEEDS as cited by Boards and Management Committees were an overall increase in service level. Medical Officers/Directors along with Nursing/Rehabilitation providers cited increased services for the elderly; while Medical Officers and Coordinators recommended early maternity discharge and palliative care. Support Service providers emphasized the need for increased support services.

- There was consensus among all groups that the major RESPONSE to future needs should be increased funding and/or staffing.

- The major STRENGTH of the program according to Boards, Management Committees, Coordinators and Support Service providers was staff qualities. Most frequently mentioned by Medical Officers/Directors was the community base of the program, and by Nursing/Rehabilitation, the coordination of services.

- All groups, except Support Services providers, cited insufficient funding and/or staffing as the major WEAKNESS. Support Services saw the lack of social entry as the major flaw.

- According to Boards, Coordinators and Provider groups the essential REMEDY was increased funding and/or staffing. In contrast, Medical Officers/Directors and Management Committees were most concerned with the need for increased physician awareness and incentive to make use of the program. Many Support Service providers were in favour of social entry.

- Responses of Boards and Management Committees were quite similar, perhaps reflecting their similar local/community base and their similar role and involvement in the program.

Further analysis of each respondent group was undertaken to determine whether distinctive differences existed within subgroups as compared with the total group. The highlights of the findings were:

- Boards tended to emphasize operational matters and concerns such as costs and funding, need for local planning and decision-making and a need for Family & Community Support Services to provide support services.

- Directors and Medical Officers of Health tended to address medical aspects of the program and the value of having the program based in Health Units.

* Management Committees tended to focus on specific local problems and needs. While they recognized lack of funding as a weakness, they tended to suggest improvements to management of the program (rather than simply increasing funds) to meet increasing demand.

* Home Care Coordinators and Supervisors tended to emphasize adminstrative concerns such as delivering services over a large area, lack of awareness, funding, and fee schedule problems.

* Responses from Nursing and Rehabilitation service providers tended to be client-oriented (rather than system oriented) and focussed on needs for increased services, particularly rehabilitation services.

* Support service providers tended to be client-oriented and concerned about enabling more people to have access to services, especially support services.

CHAPTER 4: CLIENTS OF THE COORDINATED HOME CARE PROGRAM

4.1 CHAPTER OVERVIEW

The purpose of this chapter is to summarize the views of two groups of Coordinated Home Care Program clients and/or family members. The first group was interviewed by members of the project team; the second group submitted letters.

The majority of clients indicated a high degree of satisfaction with the services received from the Coordinated Home Care Program. This was the case for both those who were interviewed and those who submitted letters.

4.2 CLIENT INTERVIEWS

A total of 115 separate client interviews were held, an average of four to five interviews in each Local Health Authority. The following table summarizes the basic charactistics of the sample.

TABLE 4.1

Characteristics of Clients Interviewed

	Number	%
Location:		
Urban	32	27.8
Rural, Towns, Villages	83	72.2
	115	100.0
Sex:		
Male	35	30.4
Female	80	69.6
	115	100.0
Length of Time on Program:		
Less than 6 months	25	21.7
More than 6 months	83	72.2
Unknown	7	6.1
	115	100.0

As shown in Table 4.1, the majority of respondents lived in a rural environment (i.e., in towns, villages and rural areas throughout the Province). Females outnumbered males by about two to one. The majority of clients had been clients of the program for more than six months. Although the interviewers did not specifically inquire about the age of the respondent, most (probably more than 80 percent) appeared to be over sixty-five.

The principal finding from the analysis of interviews was overall satisfaction with the program. Seventy-one clients (61.7 percent) indicated the program had been "Very Helpful" and forty-two (36.5 percent) had found it generally helpful. Only two clients (1.7 percent) indicated it has not been helpful.

Many clients cited one or more aspects of the program that they had found helpful or that they valued. Some of the more frequently mentioned were:

* Being able to stay at home rather than enter an institution, and being able to come home from hospital sooner (34.7 percent of clients interviewed).

> "The doctors told me I had to go into a nursing home, but I refused. I said I wasn't ready for that yet. So this Home Care was arranged for me."
>
> "Home Care was more helpful than we can express. We run a foster home here. My husband wanted to be with the children. He died at home with all of us here.... Without it we would have missed a lot, even the final goodbye."
>
> "My wife is in hospital now. They probably would have put me in too if there wasn't Home Care."
>
> "Home Care kept me out of a nursing home, where I'll never go as long as I can walk on my own two feet."
>
> "We both would have had to stay in hospital longer if Home Care wasn't here. Last place to be is in a hospital."
>
> "There's not enough room for all us old people in the hospital."

* Reassurance, advice and sense of security (e.g., help in an emergency) provided to the individual and family members (27.8 percent of clients interviewed).

> "Home Care gives me the confidence to stay alone here on the farm where I want to be. It allows me to be as independent as I can."
>
> "I am afraid that I'll have another attack.... The nurse is always there to watch out for me.... My doctor only works Tuesdays and Thursdays, but the nurse always comes."
>
> "I'm sort of shut-in, so it's good to know that things are not as bad as they seem, that my blood pressure is OK."
>
> "When a person feels down, you can talk to the nurse and get advice about your problem."
>
> "After my sister had her operation, I offered to come stay with her for a while. I didn't know much about changing her bag, but the nurse was there to show me and to see how things were coming along."
>
> "My husband at one point was taking 18 pills a day. The nurse helped sort them out for me, one week at a time."
>
> "I wouldn't have ever attempted to care for Mom without the program's support."
>
> "Home Care has been a big help to Mother. It's taken a load off my mind, especially now during harvest."

* Qualities of the nurses (13.9 percent)

> "That nurse is a good one."
>
> "The nurses are a great bunch."
>
> "That nurse was the best in the world--she called on me like a friend."
>
> "They know what they're doing."

- * Equipment and aids provided through the program (9.6 percent)

> "They got me all this oxygen equipment. Otherwise I would be in a nursing home."
>
> "They offered us a lot of help. They got us some aids for the bathtub."
>
> "If this equipment wasn't available and if the nurses didn't come to see us, I'd be in the hospital. I intend to stay in this house to my dying day."

- * Support services such as homemaking or meals (9.6 percent)

> "My homemaker has been a great help."
>
> "I couldn't get along without my homemaker."
>
> "Meals on Wheels is a very good feature, especially at the price."
>
> "The meals are a good part of the program, especially since I need a salt-free diet."

When asked how the program could be more helpful, the majority of clients (69.6 percent) could think of no way that the program could be improved, with many people saying: "Couldn't be better"; "Have no complaints"; "It's just fine the way it is"; and, "Don't kill the golden goose."

Thirty-five clients commented on the program's deficiencies or offered suggestions for improvement. (Many of these clients had said the program was very helpful.) The most frequently mentioned were:

- Need homemaker or more homemaker help	(8 clients)
- Need handyman, heavy housework help	(8 clients)
- Need more rehabilitation services	(7 clients)
- Need transportation (within town or to city for appointments)	(7 clients)
- Meals could be improved	(4 clients)
- Costs of medication/supplies a burden	(4 clients)
- Lack of services on the weekend	(3 clients)

The above comments tend to focus on Support Services, i.e., maintenance of homes and property, transportation, and meals. One of the two persons who responded negatively to the program, cited her discontent with one support service by stating "They wouldn't provide the home help I need when I don't feel good--all they would do is clean my oven!"

In summary, the Coordinated Home Care Program is well supported by clients included in this study. Three final quotations illustrate the depth of its value:

> "Without Home Care, I would be dead.... Home Care kept me alive."
>
> "I feel the best I have in three years. I'm even driving my car again. And a lot has to do with Home Care."
>
> "I think it's fantastic. For the first time since the accident (in which I was injured and lost my sight), everything's starting to come together."

4.3 CLIENT LETTERS

A total of 69 letters were received from current and former clients of Home Care or their representatives. The following table summarizes the basic characteristics of this group.

TABLE 4.2

Characteristics of Clients Who Submitted Letters

	Number	%
Location:		
Urban Rural,	17	24.7
Rural, Towns, Villages	45	65.3
Unknown	7	10.0
	69	100.0
Sex:		
Male	19	27.5
Female	39	56.5
Couples	11	16.0
	69	100.0
Length of Time on Program:		
Less than 6 months	15	21.8
More than 6 months	37	53.6
Unknown	17	24.6
	69	100.0

As shown in Table 4.2, the majority of letters were from clients residing in rural areas who had been receiving services for greater than six months. Most letters were from female clients, but interestingly, 15.9 percent were from married couples where both husband and wife received services.

The principal finding from the analysis of client letters was a high degree of satisfaction with the program. A total of 61 clients (representing 88.4 percent of the respondents found the program either "Very Helpful" (81.2 percent) or "Helpful" (7.2 percent). A further 7 clients (10.1 percent) found the program "Helpful" but felt it had some deficiencies. In contrast, only 1 client (1.5 percent) said the program was "Not Helpful".

The most appreciated aspects of the program were:

- staff dedication, excellence and superior character (e.g. "friendly, competent" nurses, "cheerful" and "supportive" homemakers, and "capable" therapists);
- services to handicapped persons;
- access to respiratory and functional aids in the home;
- opportunity for increased family participation following the birth of a child;
- Meals-on-Wheels services;
- personal care and supervision in Senior Citizen Lodges;
- respite for family caregivers;
- support for family members who chose to care for terminally ill persons at home;
- moral support and assurance of availability of services;
- provides physicians with better information about clients' health;
- improved physical and mental health;
- emergency intervention (in 1 case) which helped to save a life; and
- convenience.

Special note was made of those letters in which respondents explained the direct effect of the Coordinated Home Care Program on their lives. A number of clients (14) felt that home care services enabled them to remain in their own homes rather than live in a nursing home or auxiliary hospital. Several of these clients indicated that they would have refused to leave their homes regardless of the consequences. Some indicated they were able to leave hospital sooner following surgery; others avoided hospitalization with the help of in-home equipment and care.

The following comments were provided by 7 clients who were satisfied with the program but felt there were some deficiencies:

- lack of blood testing in the home;
- insufficient home care services for the handicapped - physiotherapy, special aids (such as electric wheelchairs, evening homemaker services, transportation);
- cutbacks in physiotherapy services which limited their benefit; and
- limitations involving level of services - lack of service for a period of time and lack of weekend and respite services.

The one telephone call (in lieu of a letter) allocated to the "Not Helpful" category was from a handicapped client and mother of 5 children who was to be "cut off" Home Care on January 1, 1983 apparently due to lack of medical need for services. The client felt that receiving Homemaker services alone would have enabled her to avoid institutionalization.

The following quotations are typical of letters received from clients:

* Regarding the staff:

> "I love those nurses, they are so kind and thoughtful and a delight to be with."
>
> "Since I've had her (a Homemaker) I've learned to laugh again."
>
> "It is not only the work she does but also the friendly, cheerful and understanding way in which she carries out her various tasks, that make her services so valuable to us."

"God bless them all, they are caring girls."

"It makes us feel good to belong to a community that has such professional services supplemented by excellent volunteers."

* Regarding the Coordinated Home Care Program:

"a lifeline to the disabled."

"one of the best things they did for the elderly."

"made her feel she was not taking charity (and was) more independent and self sufficient."

"I feel at my age I'm still useful, and able to look after myself...."

"Institutionalization would be heartbreaking."

* Regarding the future of the Coordinated Home Care Program:

"It is our hope that this wonderful service at its present standard will be continued."

CHAPTER 5: SUBMISSIONS

5.1 CHAPTER OVERVIEW

This chapter reviews 85 submissions from a variety of sources. These include:

* Associations/Groups - Designated for Interview
* Letters - Non Clients
* Family and Community Support Services
* Institutions
* Associations - General
* Miscellaneous Submissions

Material in this chapter is rich in detail. It is primarily based on well written documentation submitted to the study team by respondents. The level of detail presented here is likely to be of value to program development staff who may be in a position to use it for initiating program changes. This chapter will also be of special interest to associations that were interviewed, and to other respondents. As will be evident, the issues identified in this chapter are often at a higher level of abstraction than those in the previous two chapters. The increased abstraction reflects the nature of the respondents and their interests.

Since this chapter summarizes and reports on submissions by source category, repetition is unavoidable. This is related to the fact that certain views were held in common by several groups. Information is not as highly summarized as in Chapter 3 because the number of responses were fewer in each source category, and because patterns were less evident.

The main issues of Chapter 5 bear greater similarity to those identified by urban and mixed program respondents in Chapter 3, than by the rural ones. This similarity is related to the urban character of all of the associations and most institutional respondents.

Based on the submissions received, there appears to be a STRONG LEVEL OF SUPPORT for the Coordinated Home Care Program. Critical comments were found in many letters; however, this general tone invariably suggested that criticisms were being provided in the spirit of helping to make a good program better. Respecting this intention to be helpful, this chapter pays careful attention to program weaknesses and other issues identified by respondents.

Other important findings of the chapter include: (1) the existing medical entry criterion is contentious; (2) expansion of program scope is a common theme; and (3) views held on the Coordinated Home Care Program are diverse. Further findings in each of the six source categories are presented in the separate sections of this Chapter.

5.2 ASSOCIATIONS/GROUPS - DESIGNATED FOR INTERVIEWS

Nine key associations, whose members are integrally involved with the Coordinated Home Care Program, were designated for interviews by the Steering Committee:

* Victorian Order of Nurses
* Alberta Association of Registered Nurses
* Alberta Association of Homemaker Services
* Alberta Medical Association/Committee on Aging
* Provincial Senior Citizens Advisory Council
* Alberta Council on Aging
* Health Unit Association of Alberta
* Alberta Nursing Home Review Panel
* Alberta Hospital Association

The first six groups submitted detailed briefs prior to or following an interview. The Health Unit Association of Alberta resubmitted a previous paper on changes to the Coordinated Home Care Program Regulations and gave an interview with its Executive Director, Mr. J. Mason. The final two groups provided interviews only, one with Dr. H. Hyde as former chairman representing the whole of the Alberta Nursing Home Review Panel (which ceased to exist after publication of its report), and one with Mr. D. MacGregor, the Executive Director of the Alberta Hospital Association, representing his association. Each interview, conducted by the Project Director of the study, was approximately one and a half hours in length.

In summary, all nine associations (or their representatives) extended STRONG SUPPORT for the Coordinated Home Care Program. With the exception of the Alberta Association of Homemaker Services, all others clearly favoured both a NON MEDICAL ENTRY (to permit the delivery of support services), and some degree PROGRAM SCOPE EXPANSION. Ideas for program scope expansion were of a specific as well as more general nature. For example, inclusion of orderly services was suggested by the Alberta Medical Association Committee on Aging; while the development of a comprehensive, continuum of services (particularly for the elderly) properly linked to the institutional sector, was advocated by the Alberta Council on Aging and the Provincial Senior Citizens Advisory Council. The Alberta Association of Homemaker Services did not state Association positions as such, but presented the views of its membership from six regions of the province. Mixed opinions were held on departing from the medical entry criteria, with only one region expressing an unequivocal "no". The remaining regions held differing views, however, tending to some degree of acceptance of a "social entry". The question of program scope expansion received limited discussion by the Alberta Association of Homemaker Services.

FRAGMENTATION OF SERVICES and the need for coordination with the institutional sector was noted directly or indirectly by every group. The need for COMPREHENSIVE ASSESSMENTS to determine client service needs was a strong theme for most respondents.

The question of FEES arose in two forms: (1) the confusion between the Family & Community Support Services fee schedules for support services and those of the Coordinated Home Care Program; and, (2) the question of what fees, if any, should be charged. Some level of client payment for support services was advocated by members of the Alberta Association of Homemaker Services, the Alberta Council on Aging, and the Health Unit Association of Alberta. Home care (including support services) was seen to be an integral part of overall health care services by the Alberta Association of Registered Nurses, and therefore, this association felt that all Coordinated Home Care Program services should be fully insured.

The division of RESPONSIBILITY for funding and monitoring health care delivery between Alberta Social Services and Community Health and Alberta Hospitals and Medical Care was seen to lead to planning, coordination and communication problems. The Coordinated Home Care Program was not perceived to be a true alternative to institutionalization, or an integral part of the continuum of health care services available to Albertans because of the dominance of the institutional sector. The Executive

Director of the Alberta Hospital Association expressed the lone opinion in this section that the Coordinated Home Care Program might be more effective if it were part of the hospital system. The Alberta Association of Registered Nurses and the Health Unit Association of Alberta firmly endorsed the continuation of the program through the Local Health Authorities.

REALLOCATION OF RESOURCES (over time) from the institutional sector to the community health sector was recommended by the Provincial Senior Citizens Advisory Council, the Alberta Council on Aging, and the Health Unit Association of Alberta .

The Provincial Senior Citizens Advisory Council and the Alberta Council on Aging expressed strong concerns that their successive recommendations of previous years HAD NOT BEEN LISTENED TO. One of them noted that the results of other previous studies on home care had not been released by Alberta Social Services and Community Health.

The need for an EVALUATION of the Coordinated Home Care Program, above and beyond this review was expressed by the Alberta Council on Aging, Provincial Senior Citizens Advisory Council, and Alberta Association of Registered Nurses. The latter two associations called for a study comparable to the recent Canada/Manitoba Home Care Study which reported substantial cost-effectiveness of home care in Manitoba.

The ability to demonstrate program COST EFFECTIVENESS was questioned by the Alberta Medical Association/Committee on Aging, the Health Unit Association of Alberta, Mr. MacGregor of the Alberta Hospital Association, and Dr. Hyde of the Nursing Home Review Panel. The problem of demonstrating cost savings by one department's programs on the budget of another was specifically cited. Successful home care was also expected to increase costs to the institutional system because patients require higher levels of care upon admission to institutional care after being maintained at home for the maximum length of time possible.

Specific REGULATIONS CHANGES were submitted by the Health Unit Association of Alberta and the Alberta Association of Registered Nurses. These changes reflected the positions of the respective association on home care and on matters of more direct concern to their memberships. Two special PHYSICIAN CONCERNS were raised by the Alberta Medical Association/Committee on Aging, and by Dr. Hyde of the Nursing home Review Panel: (1) remuneration for physicians who have patients on home care, and (2) the need for creating mechanisms which simplify the effort for a physician to place patients on home care, compared to admitting them to hospitals.

Other issues raised tended to be specific to each association. Readers interested in more detailed comments provided by each of the nine associations will find an extensive summary of views submitted to the study team in subsections 5.2.1-5.2.9. Each subsection begins with a brief introduction of the philosophy or purpose of the association, or other relevant descriptive material. The introductions borrow heavily from documentation provided by respondents. All distinct recommendations in the briefs are quoted. Where possible, comments arising out of the interviews are reported in the order of the general questionnaire of Appendix B.1.

Readers for whom this section has provided a sufficient description of the views of associations/groups may wish to proceed to the review of (non client) letters found in section 5.3.

5.2.1 Victorian Order of Nurses - Province of Alberta

The Victorian Order of Nurses has provided services in Alberta since 1898, when the province was still part of the North West Territories. District or visiting nursing care was established in 1909; in 1970, the Calgary Branch initiated services in the first coordinated Home Care Program in the province. The Order continues to provide services in major and other centres in Alberta as a voluntary non-profit vendor to Home Care Programs.

The position of the Victorian Order of Nurses in their brief was that it is a "founding member" of the Alberta health care system, providing continuous service since its outset. The Order expressed a commitment to cooperating with all community care providers in a flexible, responsive way to meet community needs, in a manner which does not compromise standards of care. It urged the Government to initiate cost analysis studies and to review the total contribution of the Victorian Order of Nurses to the development and improvement of health services as a whole, before contemplating major shifts in the provision of home care.

The Coordinated Home Care Program and its objectives were fully supported, and the Government was commended for its implementation and direction of the program. The Order also commended the government's commitment to the voluntary sector. Two major concerns were raised regarding: (1) the perception that the role of the Order is perceived differently at the Ministerial level than at the Medical Officer of Health, or Coordinator level; and, (2) the perception by the Order that it is being relegated to the position of "servant" in a "master-servant" relationship.

These views formed the main elements of a brief to the Caucus Committee on Social Services and Community Health, submitted by the Order in September 1981. The same concerns continue to be held by the Order and were resubmitted to this study both in writing and during an interview with senior regional representatives.

The basic PURPOSES and ACHIEVEMENTS of the program identified by the Order were common with other provincial views expressed in Chapter 3. A minor variation was the emphasis that the purpose of the program was to be a vehicle for arranging and coordinating services already in existence and for developing new ones. Special mention was made of the achievement of a palliative care service in the Calgary program.

Current service gaps were difficult to assess from a statistical standpoint since the Order has become one step removed from potential customers. Further difficulties in assessing gaps were attributed to the fluctuation of referral volumes from program to program as well as within the same program at different times. A service gap identified concerned people who require Homemaker, Meals on Wheels and other support services, but who are not eligible for admission because they do not meet the medical entry criteria.

FUTURE/CURRENT needs identified include:

- Care for young physically handicapped persons who could live alone if help were available
- Extended program scope (Male attendants/Orderly Service/Homemaking/Housekeeping) provided on a flexible schedule basis
- Respite care to provide relief to families of the elderly, severely handicapped, or medically at risk children
- Foot care for the elderly

The preferred RESPONSE to meeting these needs was for the Province to proceed with careful expansion matched by appropriate funding.

Program STRENGTHS recognized by the Victorian Order of Nurses included recognition by government that Home Care is a practical alternative to institutionalization, and that Albertans have access to the program provincially.

While local autonomy was seen as a strength for ensuring program relevance, it was also viewed as a weakness since it has led to differential treatment of the Order by local programs. Local autonomy was also considered to be a weakness, since it generated non-uniform admission policies, differing reporting methods, differing decisions on resource allocation, and differing levels of service provided to recipients with common needs.

Further WEAKNESSES noted by the Victorian Order of Nurses included: (1) a concern with high program overhead costs (compared to direct service expenditures), (2) communication problems due to the growth of the Home Care bureaucracy, and (3) increased costs to the Victorian Order of Nurses (since the introduction of the Coordinated Home Care Program for extra conferencing, billing and reporting requirements).

A major concern was that the Order has no representation on the Calgary and Edmonton Home Care Management Committees. It was the Order's view, as a major service supplier, that it can contribute valuable field level knowledge and experience to these committees. The movement towards a control mode in the program, more attuned to the mechanics of coordinating services than to caring for patients, was seen to be an overall concern.

Some remedies suggested were:

- emphasize care oriented coordination rather than control;

- review present structure of services prior to expanding the program to accommodate more difficult services and needs;

- review funding to take into account local variations in needs and program development history;

- compare total Coordinated Home Care Program budget allocations to the nursing service budgets of larger hospitals, nursing homes, and auxiliary hospitals to determine their adequacy; and,

- recognize the direct service and indirect social benefits of volunteer time and expertise, particularly when it has had the advantage of a history of successful service that is much longer than the Coordinated Home Care Program.

5.2.2 Alberta Association of Registered Nurses

The role of the Alberta Association of Registered Nurses, as established by statute in 1916, is to register and discipline members; and to develop, implement and evaluate standards of nursing practice and education in order to achieve the goal of providing safe, competent, and ethical nursing care to society. By the nature of its wholistic, promotion, maintenance, and care centred activities, and by virtue of numbers, nursing is the predominant discipline in the provision of Home Care Services.

The Alberta Association of Registered Nurses strongly supported the objectives of the Coordinated Home Care program and its contribution to serving the needs of the elderly, the chronically ill and disabled of all ages. The Association's brief addressed two areas: changes to the regulations governing the Coordinated Home Care Program, and a summary of recommendations addressing five major areas. During the interview with senior executive members of the Association, further elaboration of these areas was provided, as were comments on other program strengths and weaknesses.

Regulation changes recommended by the Alberta Association of Registered Nurses cover the following areas:

- delete definitions for "home help", and "homemaker service", since these are task definitions more appropriately stated in job descriptions than legislation;
- include provision for the services of a nutritionist, since a significant need exists in this area;
- delete references to the structure and responsibilities of the Home Care Management Committee, as this is a matter for the Health Unit Board to deal with rather than in legislation (should Boards choose to have committees, a registered nurse should be a member). Similarly, leave the matter of titles ("Home Care Coordinator") to the Board;
- amend admission requirements to ensure portability is to include service to patients registered in health plans of other provinces to avoid service delays;
- eliminate the limitation that compares cost of Home Care service with institutional care, since Home Care is a unique component of the health care system;

- add the ability for the "coordinator" to prescribe support services if his/her assessment of the persons home and condition so warrant;

- reformulate sections of the regulations dealing with confidentiality to be consistent with other provincial Acts; and,

- make all Home Care services insured services under the Alberta Health Care Insurance Plan, thus providing services at no cost to the patient.

Seven other recommendations were presented dealing with the following:

Authority:

1. "The Alberta Association of Registered Nurses endorses the current philosophy for the Coordinated Home Care Program. The Alberta Association of Registered Nurses recommends that home care should continue to be community based and remain under the jurisdiction of the Local Health Authorities, governed by Provincial Home Care Regulations."

Eligibility:

2. "The Alberta Association of Registered Nurses strongly recommends that support services become an entry point to the home care program with or without the need for professional health services."

The Association clearly advocates the inclusion of Homemaking and other support services, particularly since these are the greatest needs of the elderly (who currently are the largest proportion of the provincial caseload). The Association expects since long term health care costs will likely be reduced as a result of this inclusion into the program."

Insured Coverage:

3. "The Alberta Association of Registered Nurses recommends that service delivery in the home should be available to individuals insured in both Alberta and other jurisdictions."

4. "The Alberta Association of Registered Nurses recommends that the present fee for service be abolished."

Funding:

5. "The Alberta Association of Registered Nurses recommends that the home care program continue to be totally funded provincially."

This recommendation reflects a desire to see some degree of program consistency throughout the province, recognizing that a potential for disparity exists, if funded locally.

6. "The Alberta Association of Registered Nurses recommends that funding of home care be based on a long range plan."

The Association referred to the results of the Canada/Manitoba Home Care Study, which indicated significant savings to the system by including support services as an entry point to home care, as a possible starting point for development of a plan.

Assessment of Needs:

7. "The Alberta Association of Registered Nurses recommends there be a multidisciplinary needs assessment of the client/family which is collaborative and coordinated, and that a registered nurse be a participating member of this team."

Current assessment methods were seen to be inconsistent and fragmented across the continuum of care (private homes/group homes/seniors dwellings/lodges/etc.)

During the interviews it was pointed out that the Family & Community Support Services program cannot be considered a substitute for home help from Coordinated Home Care. The Family & Community Support Services program is not available everywhere; it is of limited priority for many municipalities under whose jurisdiction it falls; and it has different cost implications to the recipient.

FUTURE PROGRAM NEEDS were identified as: palliative care in the home; respite care to assist families of elderly, chronically ill and/or disabled patients on home care; and the need for additional resources to deliver these new programs.

Defining the program at the regulations level was seen to be a STRENGTH, helping to ensure a reasonable degree of provincial consistency. A WEAKNESS was that physicians do not appear to find it financially attractive to admit patients to home care.

5.2.3 Alberta Association of Homemaker Services

The Alberta Association of Homemaker Services represents public and private, profit and non-profit, homemaker agencies in Alberta. Its purpose is to enhance the quality and availability of homemaker services throughout the province. The formal brief presented was the outcome of a review of the Coordinated Home Care Program by member agencies from seven parts of Alberta. Accordingly, there were differing views on topics according to their relevance to the respective regions. The Alberta Association of Homemaker Services, as such, took no position on issues, but rather acted as a vehicle for bringing the views of its membership to the study. These views are summarized by region in topic form.

Regions 1 and 2 (North)

Public Awareness:

Confusion exists about the program, its services, entry criteria etc. for providers, clients and the public. More advertising is required to create an awareness of the program.

Program Consistency:

Every person should have the right to receive home care services. Some programs cater to those 65 and over.

Personal Care:

There is a lack of consistency regarding the use of homemakers as personal care attendants. Using homemakers throughout the province as personal care attendants would free up nurses to do medical treatments and assessments, and would produce cost savings to the program.

Overlapping Services:

Some programs are retaining health aides as staff members. Existing community resources and agencies should be used on a contract basis rather than hiring homemakers for the program.

Advisory Committee:

Membership on some local program committees is not as originally specified. Specifically, the Alberta Association of Homemaker Services is not represented on Management Committees, thereby leaving out representation from those who deliver services.

Client Assessments:

All support services should be provided through the Coordinated Home Care Program. Currently separate assessments by Home Care and Family & Community Support Services often lead to different prescriptions of time required for support services. Home Care tends to cover minimum levels of service, leaving Family & Community Support Services to pick up the balance, which is usually necessary.

Fee for Support Services:

A flat rate or no fee at all would be better than the two different fee scales (Coordinated Home Care Program & Family & Community Support Services). Why should there be a charge for support services but not for medical services?

Social Entry:

A non-medical entry might be considered where no Family & Community Support Services are available.

The Town of St. Paul, however, felt that there is no need for changes to the Coordinated Home Care Program and that social entry was not required. Permitting social entry to the Coordinated Home Care Program would create a redundancy with homemaker service from Family & Community Support Services. Alternatively, the Family & Community Support Services program would have to be incorporated into the Home Care Program.

Appeal Procedure:

Greater awareness of appeal procedures by clients was necessary.

Region 3 (West of Edmonton Area)

Social Entry:

This was considered acceptable within limits [unspecified].

Willingness to provide service:

Some nesitancy was reported on the part of the Coordinated Home Care Program to provide homemaker services through contracts. This was seen to limit the accessibility of clients to services that would allow them to remain at home.

Fee Scales:

Too great a difference exists between Home Care and Homemaker fee scales. Family & Community Support Services pick up the difference between actual changes and Home Care payments, thus subsidizing Home Care.

Hours Paid:

Labour standards require a minimum 3 hours of service for a homemaker. Home Care often asks for less, leaving the homemaker service agency to pay the difference.

Availability:

Homemakers are expected to be available on extremely short notice (without compensation) and irritation is expressed by Program staff if they are not.

Region 4 (Edmonton Area)

Limitation of Hours:

Local decisions place limitation on the level of service provision (total hours of support services) thereby depriving Home Care clients of needed help.

Child Care:

Why cannot a homemaker supervise children while their parent is away (e.g. a mother obtaining the service, taking the advantage of the opportunity to see a physician since someone is at home)?

Existing Resources:

Existing services and volunteers should be used to the fullest extent before local programs consider retaining full time staff.

Emergency Review:

A person refused admission now waits a month for a Board meeting to have the case reconsidered. Provision for emergency review would be valuable.

Region 5 (East of Edmonton)

Fee Scales:

The difference exists between Home Care and homemaker agency fee scales is too great.

Social Entry:

Social entry should be available to some clients, e.g. the elderly awaiting to enter an extended care institution.

Cooperation:

Excellent cooperation exists between nurses and Homemaker Supervisors

Personal Care:

This could be done by a trained homemaker, freeing the nurse for other care.

Region 6 (Central)

Support:

Strong support was expressed for Home Care.

Fee Schedule:

All clients should pay for support services. Rate differences between single clients and couples should not be too large.

Social Entry:

Home Care should retain its medical entry criterion and not expand to services to the social area.

Region 7 (South)

Major Strengths:

People are staying home longer and families are being kept together in our communities because of Home Care.

Weaknesses:

Portability of benefits does not exist for clients arriving from other provinces.

The Coordinated Home Care Program does not cover the frail eldery, the severely handicapped or children of young parents that are terminally ill. The absence of a non-medical entry for extenuating circumstance is a weakness. A social entry is not generally desirable.

Hours:

After hours and weekend services are necessary but are not usually provided.

Budget:

Home Care budgets should increase by amounts equal to hospital cut backs (resource shifting)

Fee Scales:

Conflicts exist between Home Care and Homemaker fee scales. A flat rate should be applied or fees should be removed.

Public Relations:

More Public Relations is necessary and should be directed to informing the public, professionals, and clients about the program.

Discharge Planning:

Adequate discharge planning is required - 48 hours notice by hospitals for homemaker services would be helpful.

Unit Costs:

The rate for homemaker services varies too much across province and is unclear since part of the service needs are often picked up by Family & Community Support Services.

In summary, the most common issues were: fees (the discrepancy between Home Care payments and real costs); social entry (one unequivocal refined "no", the other regions offering mixed views, on generally tending to an acceptance of some degree of social entry); and lack of public awareness about the program (among physicians, nurses, the public etc.). In general, the Coordinated Home

Care Program was strongly supported by all regions and people are seen to have benefitted from it. The major weakness of the program was lack of standardization on the availability of support services. This was attributed to differences in the way individual coordinators approve homemaker and other support services.

5.2.4 Alberta Medical Association/Committee on Aging

As an association, the Alberta Medical Association does not address home care issues except as they may arise through its Public Health Committee and Committee on Aging. Individual physicians, who are members of the Alberta Hospital Association, do participate in the home care program through referrals or as medical officers. The official position of the Alberta Medical Association regarding home care is the result of recommendations of its Committee on Public Health to the Association's Board of Directors, who subsequently forwarded the recommendations to the Minister of Alberta Social Services and Community Health as an official position. This position was reiterated in a response to the general study questionnaire by the Committee on Aging:

> "The Committee [Public Health Committee] understands that a major limitation to the effective use of home care is the current level of underfunding which in many cases prevents the application of successful rehabilitation services. Rehabilitation under present funding is inadequate resulting in the lack of frequency of therapists' visits.
>
> The Committee recommends that the Board of Directors urge the Provincial Government to provide more funding for home care with particular emphasis on rehabilitation services."

The views of the Committee on Aging on the Coordinated Home Care Program presented at an interview and in the form of a letter (not a formal brief or Alberta Medical Association position) follow.

The Committee on Aging understood the PURPOSE of Coordinated Home Care Program to be to keep persons at home thereby improving their lifestyle. The function of the program was seen to be coordination of services to these patients. The major ACHIEVEMENT of the program was the provision of care in a form that is better for the patient than may be available through other means. The principal GAP in services identified was that there are not enough of them - demand exceeds supply. In particular, a shortage of male orderlies and similar personnel exists, and hence the needs of certain groups at not being met.

The greatest STRENGTH of the program was that it provides care in the home, a modality that is often better for patients than other alternatives. The greatest WEAKNESS appeared to be the restriction to a medical entry. A non-medical entry point would be desirable for some patients for socio-economic reasons, but a system to control costs would be necessary as well.

Other issues of concern to the Committee on Aging included the problems of a satisfactory method of physician remuneration and the dilemma of demonstrating the cost effectiveness of home care. On this latter point, the following was stated:

> "The Committee also understands the difficulties of trying to show that home care is a cost effective mechanism of providing health care to the population. Some of these difficulties are related to the method of funding. A saving in hospital care can only be measured by the Minister of Hospitals and Medical Care. If a patient is sent from hospital to the home care program, the bed is not emptied and is immediately filled by another patient on the waiting list. If the discharged patient is then cared for at home under the cost of the home care program, this is seen as an add-on cost, and the program is funded by the Minister of Social Services and Community Health. Although it can be shown that the daily rate for a patient is less than the daily rate of a hospital bed, this fact is not reflected in the two health budgets. Although the program must be cost effective, so many variables are involved that it would be almost impossible to prove this scientifically."

5.2.5 Provincial Senior Citizens Advisory Council

This Council identifies and reviews issues, views, and concerns relevant to older people in Alberta, and provides corresponding advice to the government. The Provincial Senior Citizens Advisory Council' believes that old age should be a time of satisfaction and fulfillment. Even though the latter years may bring physical and social stresses, old age should be a time of productivity, growth and self-realization. To this end, three basic themes are seen to be appropriate for government policy, services and service delivery to older persons:

- provision for maximum independence and choice;
- encouragement of continued participation in family and community life; and
- involvement of senior citizens in the planning, development, and assessment of services.

The Council was encouraged by the recent comments by the Honourable Dave Russell regarding the need to reduce institutionalization.

The major points of the brief were:

1. "The Provincial Senior Citizens Advisory Council has recommendations on home care in each of the five reports which it has made to date and is including a recommendation on it in its 1981 report."

2. "Council believes home care should be comprehensive, include social support services as well as health services, and be available on both a long term and short term basis."

   "There was much disappointment when the Coordinated Home Care Program was announced in March 1978, for it clearly was a 'health-oriented' service (to be eligible to obtain home care, persons must require a professional health service) and also a short term service (the emphasis was on rehabilitation not maintenance)."

3. "Recommendation in the 1980 report states the Council's position most clearly.

   - that home care be extended to persons who are frail and disabled, but who do not necessarily need a professional health treatment service as is now required, and that social support services be an integral part of home care as is health services; consideration should be given to developing a joint assessment mechanism with institutional services."

The concept of joint assessment was elaborated in the 1981 Annual Report in the context of "joint multidisciplinary assessment process" which was seen to be the link between home care and nursing homes, and auxiliary hospitals.

4. "Linkages between home care and institutional services and shifting of resources from institutional to community care."

The Council expressed the view that joint assessment should consider home care as the first alternative place of care. In addition, greater coordination between the institutional and community sectors and a greater control over institutional beds was seen to be necessary. If home care were expanded and greater coordination achieved, then there could be a gradual shifting of resources from the institutional to the community sector. A resulting impact would be that in the future, proportionally fewer beds be required for the elderly.

Council representatives expressed other concerns:

- while the Review of the Coordinated Home Care Program is of value an evaluation such as the Canada/Manitoba Home Care Study was necessary;
- that it be clearly understood the Provincial Senior Citizens Advisory Council has no anti-institutional bias, but is interested in establishing the Coordinated Home Care Program as a real alternative to the predominant alternative of institutionalization; and
- that there is too little understanding in society at all levels of the impending impact of an aging population.

Major GAPS in service were in the area of mental health and respite care for families of clients (e.g. the need for day care centres). Current program STRENGTHS included: the palliative care programs in Calgary and elsewhere; province-wide coverage; the flexible approach to service delivery (particularly in the rural areas); and the commitment and service of staff.

WEAKNESSES in the program included: the current exclusiveness of medical/rehabilitation services; fragmentation in service provision and care delivery; and the lack of a comprehensive assessment. The latter two points were a source of confusion for older persons because of the different sources of care, and separate, often overlapping, assessments which differed in their judgements on service requirements.

5.2.6 Alberta Council on Aging

The Alberta Council on Aging has been in existence since 1966 and acts as an advocate and provincial voice for Alberta's aging population. Its philosophy of health care includes the concepts of independence and dignity for the elderly, and health care being an aid and support that allows individuals to function as wholly as possible (mentally/spiritually/physically/socially). The Council supports a comprehensive, cooperative, and coordinated organization and delivery of health care to ensure the most effective and least obtrusive support required. The specific aim of health care, in the Council's view is to keep seniors in their home as long as possible, recognizing that an older persons' needs can be complicated by a multiplicity of physical problems of chronic origin, acute illness (or a combination of both), and that care required could be short or long term.

It was noted in both the formal brief and at the interview that:

- this review was not a proper evaluation;
- during the past two years various studies had been carried out by the Alberta Social Services and Community Health but none had been released;

- repeated requests by the Alberta Council on Aging in previous briefs and recommendations had stressed the comprehensiveness of care necessary for the older person and the consequent need to include home support on a non-medical entry basis; and

- in the past, the Councils' recommendations had not been taken seriously.

The Council saw "comprehensive" (as opposed to simply coordinated) home care as a priority particularly for the frail elderly who are not eligible for services under the current medical entry system, but who need chore services and personal care (bathing/foot care/nutrition).

The current PURPOSE of the Coordinated Home Care Program was to permit individuals to stay at home and to spend a shorter time in acute care settings. ACHIEVEMENTS of the program, for those admitted, include:

- assistance in preserving the family unit and close familiar relationships;

- increased likelihood of family support;

- greater personal control and independence for recipients, and better sense of wellness than in the illness oriented atmosphere of hospital; and,

- a more personal and holistic approach to health care delivery.

A particular FUTURE NEED noted by Council was the need for home support in lodges, which are no longer homes for the well but for the frail elderly.

A number of recommendations relating to program weaknesses were made pertaining to the following:

1. Fee Structure

> "The Alberta Council on Aging recommends a flat fee (on a monthly or weekly basis) be used for home support services."

This recommendation reflected the concern that there is a discrepancy between Family & Community Support Services and Coordinated Home Care Program charges for support.

2. Two Delivery Systems

> "The Alberta Council on Aging recommends that the delivery system be handled by one administrative structure in the Department."

The current split in responsibilities for medically and socially oriented services, at the municipal and provincial levels, was seen to be a major weakness.

3. Eligibility

> "The Alberta Council on Aging recommends that the eligibility for home care/support be opened to include non-medical entry."

The current system was perceived to be wasteful in that there is a built in incentive to provide unnecessary, expensive nursing care in order to be eligible for home support.

4. Staffing

> "The Alberta Council on Aging recommends that:
>
> i) Province wide standards be set for employees in the program
>
> ii) Local Boards of Health, in cooperation with universities and colleges, establish training and inservice programs to assist staff in meeting the standards
>
> iii) The province provide financial incentives in wages to encourage training."

Further RECOMMENDATIONS were: to phase in non-medical services, so that Boards of Health can train staff and prepare for increased demand; to expand patient and family education; and, to provide more intensive psycho-geriatric care and services in the future.

The major ISSUES, according to the Council, were: the interrelatedness of care requirements of the elderly; the disproportionate allocation of resources to institutional care (e.g. a one year budget at Dickensfield was compared to one year of the whole Coordinated Home Care Program provincially); and, the lack of access to, and limited availability of, non medical but extremely important care services for the frail elderly.

5.2.7 Health Unit Association of Alberta

The Health Unit Association of Alberta represents the interests of its member Health Units before the government, bargains on behalf of the management of Health Units with various professional associations and unions, and contributes to the professional development of staff and Board Members of the Health Units. While the Association did not submit a formal brief, an interview was held with the Executive Director, Mr. J. Mason, who resubmitted his paper entitled, "Home Care Regulations, Recommendation for Amendment" (July, 1982) Mason. This paper was based on the issues discussed at the Third Annual Issues Conference of the Association, and associated submissions presented to the Executive during and previous to this conference. The paper constitutes the formal position of the Association. It is based on the premise that the Coordinated Home Care Program has matured sufficiently to warrant changes to the original regulations.

The specific recommendations in the paper were:

1. "That, assuming a basic level of service is maintained, other services may be offered under the Home Care Program at the discretion of the board."

2. "That the title, Home Care Management Committee be changed to Home Care Advisory Committee and that such committees be established at the discretion of the Board."

3. "That the title Home Care Coordinator be changed to Director of Home Care."

4. "That the duties and responsibilities of the Director of Home Care be established by the Chief Executive Officer of the Health Unit."

5. "That the entry requirements of the Home Care Program be expanded beyond the present medical entry point. The need for support services should be a sufficient criterion."

6. "That requirements regarding confidentiality of home care client records be established under the Public Health Act or some other act governing such matters."

7. "That there should be no user fee for medical services under Home Care." [i.e. no user fee should be introduced.]

8. "That the user fee for support services be maintained; however, it should be sufficiently moderate so as not to discourage use of the home care program."

The main issues before the Health Unit Association of Alberta regarding the Program were twofold: (1) the establishment of a "Management Committee" as a formal requirement of the regulations appears to infringe on local autonomy and responsibility, i.e. on the obligation of Boards to use their own discretion on what committees are necessary or appropriate; and (2) the Health Unit Association of Alberta is monitoring the future impact on labour negotiations of settlements and issues affecting Home Care staff. Regarding the second issue, Coordinated Home Care Program staff must provide services, on occasion, beyond normal working hours as distinct from other Health Unit staff. The precedent setting effect this working requirement could have on salaries of other Health Unit areas, was considered particularly important.

Other observations made during the interview included:

* It was not clear whether the Coordinated Home Care Program was meeting its objective of reducing health care costs relative to acute care. Some question existed whether cost savings do occur or whether an "add-on" situation persists.

* Some Health Units had considered the philosophical issue of whether home care truly belongs in a Public Health Unit, whose primary role is prevention rather than treatment. Notwithstanding, the clear position of the Health Unit Association of Alberta was that the local community jurisdiction is the most appropriate focus for the Coordinated Home Care Program.

* The goal of keeping the patient at home was seen to be an admirable and accepted goal. The question was raised whether this view is conveniently that of the 35-40 year old, but not always that of the 70-75 year old. It was speculated that the issue may be one allowing people to make choices, rather than accepting the belief that the home environment is best. For those that wish to be in their own homes, Coordinated Home Care Program would be appropriate; for others, perhaps institutionalization was an acceptable alternative.

* An overbuilding of hospitals appeared to be underway. The view was expressed that if costs could be saved and the care were better for many at home, funds should be diverted from hospitals to Home Care.

* Family & Community Support Services and the Coordinated Home Care Program together could conceivably provide a good service, but the problem lies in the non-availability of Family & Community Support Services in all areas.

Solutions to budget difficulties facing the Health Units included: billing the Alberta Health Care Insurance Plan for home care services directly (then the problems of budgetting in the face of fluctuating caseload is passed on); and, if the growth of home care were accelerated, providing commensurate funding.

5.2.8 Dr. H. Hyde, former Chairman, Alberta Nursing Home Review Panel

The Alberta Nursing Home Review Panel was established by Order-in-Council in 1981 to study the nursing home system in Alberta in terms of its development, comparison with other provincial systems, its structure, functioning and financing, and to report to the Minister of Hospitals and Medical Care by March 1982. The Panel ceased to exist upon submission of its report as required. An interview with Dr. Hyde, former Panel Chairman, provided information that generally reflected and elaborated views in the Nursing Home Review Panel Report.

Dr. H. Hyde, while a physician, admitted to having limited knowledge about the program prior to his study. During the course of the Panel's research, it became evident to Panel members that alternative services to Home Care must be reviewed as well. Of these, Home Care was clearly a major component (in other provinces). It was also clear that the inter-relatedness of the care needs of the elderly/disabled/chronically ill required a perspective which included home care as a part of a continuum of total care. Both Dr. Hyde and the Committee believed the Coordinated Home Care Program was working well.

In the view of Dr. Hyde, the PURPOSE of the Coordinated Home Care Program was to: look after people in a non-institutional setting; treat people at an early stage of an illness to avoid hospitalization; and keep total hospital days down in the health care system.

The major ACHIEVEMENT of the Coordinated Home Care Program was keeping people out of institutions. However, patients now being admitted to Nursing Homes/Auxiliary hospitals, often require higher levels of care, due to their advanced stage of frailty upon entry, resulting from effective home care and a prolonged stay at home. Accordingly, while the net cost saving was difficult to demonstrate, it was believed to exist and to be an achievement. Another important achievement of the program according to Dr. Hyde was the confidence it provided to patients and families, allowing them to cope with illness in their own home.

The main SERVICE GAPS were related to care for all those with social entry level needs, particularly where no Family & Community Support Services programs exist. These included the chronically ill and deteriorating patients such as those with MS (largely misplaced in Nursing Homes), and the handicapped. For such patients, group home/cluster housing in which Home Care could be provided regularly was thought to be valuable. Dr. Hyde noted that appropriate housing may be as important as care for such individuals. A limited service gap appeared to exist for the mentally disturbed elderly, but it was felt that many families would find it difficult to cope for long with such patients, even with Home Care.

FUTURE NEEDS were associated with increased care requirements due to the progressive breakdown of family bonds, this breakdown affecting the young and the elderly most. Home Care was seen to be a means of supporting the the family as a unit of care. The MANITOBA MODEL of home care delivery was thought to be appropriate and worth examining for Alberta as a possible RESPONSE to future needs.

STRENGTHS of the program were its ability to provide continuity between care at home and care in institutions, and the enthusiasm and altruistic characteristics of its staff.

WEAKNESSES in the Coordinated Home Care Program were:

- the limitation of a medical entry requirement
- a lack of coordination in all areas between Family & Community Support Services and Home Care
- insufficient coordination between government departments/homecare/auxiliary hospitals/nursing homes/acute hospitals
- a lack of access to home care for some lodge residents
- the effort for a physician to get patients onto a Home Care Coordinated Program compared to admitting them to hospitals.

The most important REMEDIES proposed for meeting patient needs were: (1) acceptance of a social entry criterion, and (2) continued cooperation (in the interest of patient care, patient housing, and professional education) between Alberta Housing Corporation/ Alberta Hospitals and Medical Care/Alberta Social Services and Community Health/Alberta Advanced Education.

5.2.9 Alberta Hospital Association - Executive Director

The Alberta Hospital Association's purpose is to deal with issues of interest to its members, including liaison with government and bargaining with several unions and associations on behalf of hospitals and nursing homes in the province. Since the Alberta Hospital Association and its members have not been directly involved in home care delivery, and since a formal request to establish an Alberta Hospital Association policy statement on the Coordinated Home Care Program has never arisen, the Board has not considered the question.

The Executive Director, Mr. D. MacGregor, who gave an interview to this study, was familiar with the program, having observed its impact as a former hospital administrator. He also acknowleged a special perspective of the program having previously been a Board member for the Victorian Order of Nurses. The material that follows represents the personal observations of Mr. MacGregor rather than a formal Alberta Hospital Association position.

Mr. MacGregor was of the opinion that the Coordinated Home Care Program could be more effective if it were part of the hospital based system. The program was seen to be in a difficult position in that most of its patients are referred from hospitals yet the program is not part of the system of funding hospitals. He believed the dislocation from the institutional environment contributes to fragmentation and communication problems in the delivery of care. Within the program itself, Mr. MacGregor felt that lack of philosophical clarity existed, since home care was treatment oriented rather than prevention oriented. This treatment orientation was more appropriate to a hospital system than to a community health unit system, which was seen to be prevention oriented.

Mr. MacGregor felt the cause of prevention itself might be advanced if public health services were located in hospitals. Since health care institutions are often major employers in communities, effective prevention programs for their staff, implemented and monitored on site, could highten the visibility and acceptability of prevention in the community at large.

The primary STRENGTH of the Coordinated Home Care Program was seen to be its ability to provide the appropriate type of care to patients in their own homes. Other STRENGTHS/ACHIEVEMENTS were the possibility the program presented for family members to participate in care, reduction in travel time, etc. The major WEAKNESS appeared to be the inability to serve all who could be served, primarily due to the inadequacy of current funding.

The main CHANGE suggested for the program was the broadening of the medical entry criterion to include social entry. The result of excluding non-medical care was seen to be increased health problems.

The major questions posed by Mr. MacGregor for future resolution were political: Should the program expand? How big will the total health care pie be? How will resources be divided between the institutional sector and the community health sector where Home Care is currently located?

5.3 LETTERS (GENERAL)

Twenty-one letters, including two with petitions of 52 and 37 names respectively, were received from members of the public, presenting mainly general opinions, rather than client or provider specific views. One of the letters forwarded a copy of a brief prepared jointly by three Medical Officers of Health for submission to a meeting of their colleagues. This letter was arbitrarily classified for review in this section of the report, but could also have been included in the previous section.

The main characteristic of the responses in this section is that writers answered study questions SELECTIVELY, presenting a range of views particular to their local experience. Trends were not evident in the responses except for SUPPORT for the program in all but one case.

By calling for services that are provided elsewhere in the province, respondents demonstrated that home care VARIES from locale to locale. PROGRAM ENRICHMENT, the development of FUNCTIONAL ENTRY CRITERIA, and implementation of COMPREHENSIVE ASSESSMENTS had support from several writers. A letter with 52 signatures "implored" the continuation of the program in the Elnora area.

The sole negative respondent, while in support of providing care, felt that home care should be limited to only those services that need to be given at home, and that existing resources should be better used. In the respondent's own words,

> "Loneliness and inability to do day by day chores are the main problems we see in the area. When these are cared for, clients can cope with their chronic disease by utilizing existing facilities such as doctors offices for nursing service, out patient physio services (at the hospital) speech therapy, or O.T. at Health Unit."

The PURPOSE of the Coordinated Home Care Program, according to respondents was to: provide patients the opportunity to be at home; reduce the cost of institutionalization; and improve the quality of life and care by having treatment at home. The ACHIEVEMENTS of the program included: effective coordination of services; efficient program delivery especially, "considering the low staffing"; tax dollar savings; and provison of maternity care.

A unique example of an achievement expressed to this study was provided by a physician writing on behalf of his clinic:

> "the services have assisted physicians in the care of many patients that have required i.e. dressings, monitoring blood pressures and particularly in the care of our diabetics where...eye sight has been poor or there has been no one else around to draw up their insulin adequately and properly."

The need for 24-hour care was listed twice as a GAP in existing services. Volunteers, (paid) friendly visitors and homemakers appeared less available than desired. Target groups not obtaining services were: the permanently disabled, new mothers, and those that would benefit from palliative care and mental health services. Deficiencies in preventive services were also suggested.

FUTURE NEEDS included meals on wheels, surveillance and maintenance, and a systematic use of existing services in the community. The only RESPONSES to future needs came from the individual critical of the current Coordinated Home Care Program. This person felt that providing patient transportation to existing services, and paid friendly visitors for necessary support, were two appropriate solutions.

While the strengths were not addressed by each respondent the tone of all but one letter (as previously noted) was supportive to the program. Two STRENGTHS explicity identified were the positive efforts of local physicians, and the local authority base for the program.

The one dissenting view was clear:

> "There are no strengths....The program is an abominable waste of monies. It is top heavy with management and is mainly a political play! For those who are willing to cope, it makes their stay at home more pleasant but does not provide enough day by day service to make their stay at home possible unless client has another support system."

Program WEAKNESSES were more frequently noted. These covered the gamut: too much administration; misuse of Alberta Aids to Daily Living equipment; absence of mental health support and the need for chronic pain management; lack of 24-hour care; and a geographic area too large to be covered by the available staff.

Two particularly pointed issues raised were who is to be served by the program, and the place of home care in the health care system:

> "The present Home Care Program regulations are characterized by an expectation that each patient will either recover or expire, and therefore for whichever reason, will no longer require the services of the Home Care program. This obviously leaves out those individuals who will never recover sufficient abilities to function without the physical assistance of another person, or who have never developed these abilities due to a disability since birth.
>
> Home Care services have been developed in Canada as a care alternative which has been peripheral to the main system of medical and hospital care. Home Care has, therefore, never been a planned, integral part of the whole care system."

Some REMEDIES were: to increase/not decrease funding; to conduct comprehensive assessments; and to adopt functional entry criteria. Other recommendations by individuals included: establishing an appeal process; eliminating Home Care Management Committees; and providing equipment and supplies directly through care givers, thereby eliminating the need for local administration of the Alberta Aids to Daily Living and Extended Health Benefits programs. One petition of 37 names, circulated at a diet therapy workshop, called for the inclusion of the services of registered dietitians in the Coordinated Home Care Program.

A particularly cogent set of recommendations was presented in the brief by the three Medical Officers of Health sent to the study:

For the Acutely Ill Patient

1. "Home care services require to be planned and funded as an integral part of acute care, complementary to the capacity of acute care hospitals."

2. "Home care services for the acutely ill need to be promoted to physicians and in the community to the extent that care in the home becomes a conscious and automatically considered option."

For the Long Term Dependent Patient

1. "Home care services need to be sufficiently comprehensive and flexible to care for all long term dependant patients who reasonably can be cared for in the home. This would require a home support entry to home care."

2. "A comprehensive home support system should be seen as the primary route of entry into the long term institutuional system."

3. "The professional staff of the home care/home support system should become the primary means of assessing the need for institutional care."

The last two recommendations were noted by the authors as reinforcing the recommendations of the Hyde Report - Nursing Home Review Panel.

5.4 FAMILY & COMMUNITY SUPPORT SERVICES

In this section, fourteen letters from across the province are analyzed. The common themes were SUPPORT for the program and support for a NON MEDICAL ENTRY. Since most letters responded selectively to questions, trends are weak. An indication of the frequency of responses is provided in this section.

The most commonly identified PURPOSE of the program was to PERMIT CLIENTS TO BE AT HOME (6 out of 9 respondents), with prevention of institutionalization running second (3 out of 9). Other than those directly reflecting program purposes, no single ACHIEVEMENT was evident. The provision of medical care and supervision to the elderly in remote areas was an example of a valued achievement.

While no single service GAP stood out, service to remote parts of a local health authority area was cited by two out of six respondents. Persons not meeting medical criteria (temporarily disabled/frail elderly) and prospective clients identified after budgets were expended were further examples of service gaps.

INCREASED SERVICES TO THE ELDERLY was identified as the predominant FUTURE NEED (5 out of 7), due to the growing population of seniors. The need for services of dietitians was noted by two respondents. Other needs were those of the disabled, mentally and emotionally ill, and new mothers and mothers to be in late stages of pregnancy. Adequate coordination with long term care institutions was seen to be especially critical in the future. INCREASED FUNDING was the most common RESPONSE to future need (3 out of 6).

STAFF in the Coordinated Home Care Program were cited to be the greatest STRENGTH (5 out of 10), with communication/coordination second (2 out of 10). The confidence the program gave to families of clients, to help provide care and support, was important to one respondent.

The greatest WEAKNESS was clearly the RESTRICTION TO MEDICAL ENTRY (7 out of 11). Three other respondents implied this restriction was a weakness, two presented no opinion on the issue, and one indicated "no need" for a social entry. Lack of publicity for the program and budget problems were also important weaknesses (3 out of 7 each). Confusion over fee schedules for homemaker services was considered a weakness by two respondents.

The most common REMEDY was to establish SOCIAL/FUNCTIONAL ENTRY CRITERIA (6 out of 11). Increased budgets were perceived next in importance (3 out of 11). The expansion of program scope was important to a number of writers, particularly the provision of services to the mentally ill (2 out of 11).

TABLE 5.1

A SELECTIVE SUMMARY OF INSTITUTIONAL BRIEFS

	LODGES N = 3	RURAL HOSPITAL N = 5	REGIONAL CENTRE HOSPITALS N = 3	METROPOLITAN HOSPITALS N = 9
RESPONSES TO CHCP	Supportive	Supportive	Supportive but critical	Supportive
MAJOR/TYPICAL ISSUE	Positive, caring staff	A range of local views (PT duplication with hospital/program exclusively for elderly/ mixed views on social entry)	Impact of concurrent budget cuts on CHCP and hospitals	Supportive to social entry
SECONDARY ISSUES	Questioning validity of medical entry criteria	Consensus with others on strengths and weaknesses	High administrative cost of CHCP Cost benefit evaluation of CHCP required	Supportive to expansion of program scope
OTHER	Home Care provided to residents of these lodges; in other lodges home care is unavailable	Shift responsibility to Minister of AHMC	Need to determine impact of new trends (e.g. Geriatric Day Hospitals) on CHCP	Support for home palliative care/ certain home IV Medication/appeal mechanism

Note: PT - Physiotherapy
CHCP - Coordinated Home Care Program
AHMC - Alberta Hospitals & Medical Care

5.5 INSTITUTIONAL RESPONSES

Twenty institutions submitted twenty-one letters/briefs to the study. As in the previous section, the responses exhibited few trends. The detail presented here however, provides valuable insights and ideas for program improvement. In general, there is strong support for the Coordinated Home Care Program. EARLY DISCHARGE and CONTINUITY OF CARE made possible by home care were considered two important means of ensuring more effective use of beds. A selected summary of institutional responses is presented in Figure 5.1 on the opposite page.

5.5.1 Senior Citizens Lodges

Three submissions were received from lodges in Legal, Thorhild and Spirit River. These were brief, noting that Coordinated Home Care Program staff visited each lodge regularly to do toe nails, give baths and set hair (services not provided consistently throughout the province).

All three lodges explicity stated strong SUPPORT for the program. PROGRAM STAFF were praised implying that they were a major STRENGTH of the program. One lodge representative questioned the MEDICAL ENTRY criterion, and suggested that the needs of dependent adults were not being met as a result of this criterion.

5.5.2 Rural Hospitals

The five rural institutions who responded were:

* Athabasca Municipal Hospital District #13
* Radway Health Care Centre
* Two Hills General Hospital and Nursing Home
* High River Hospital and Nursing Home
* Brooks Health Centre

The hospitals provided responses to only some of the questions of the general questionnaire (Appendix B.1). The common theme was SUPPORT for the program, based on the tone of the letters and the achievements and strengths identified. Selected ACHIEVEMENTS were:

- the delivery of services

- follow up post discharge
- permitting people to stay at home
- freeing up beds
- delaying admission
- liaison between disciplines
- liaison between hospitals and program

Other comments identifying problems and issues were also presented. One hospital suggested a degree of program abuse existed, "people...who would be better off if their family looked after them." Duplication in funding for Physiotherapy services was noted by a respondent who thought that patients should go to the hospital for such services. Another writer left the distinct impression that the program was exclusive to the elderly and suggested it be "continued and expanded to include services to people of all ages who are in need of the services provided by the program."

Two hospitals in the same geographic area addressed the need for social entry; one supported it, the other did not:

> "if promotion of personal health and accountability for one's lifestyle is to remain a part of the overall objectives of Home Care, then a further avenue of entry into the program is necessary. For example, consideration of a social need entry is proposed."
>
> "If a social entry was added, I feel the program would mushroom beyond control, and could involve some abuse of the program. Also Social Services are available to our people for a small fee."

One hospital recommended that responsibility for the Coordinated Home Care Program be transferred to the Minister of Alberta Hospitals and Medical Care.

5.5.3 Regional Centre Hospitals

Three briefs, one from each of the two Lethbridge hospitals, and one from the Medicine Hat and District hospital, were received. Two of the briefs were positive to the program, the third, while implicitly supportive, was critical of the program.

The CARING and COOPERATIVE attitude of program STAFF, and EARLIER DISCHARGES were two important ACHIEVEMENTS of the program.

The major ISSUES differed among hospitals. They included: operational/logistical concerns (too short a notice for referral to home care just prior to discharge); concern over impacts of simultaneous budget restraints on both the Coordinated Home Care Program and hospitals; fundamental criticisms about the program operations (high administrative costs/erosion of voluntary sector through hiring of program staff rather than contracting services, fee schedule differences compared to Family and Community Support Services).

The impact of SIMULTANEOUS BUDGET RESTRAINTS on both hospitals and the Coordinated Home Care Program was also presented at a public meeting:

> "If the Department of Hospitals and Medical Care restricts hospital budgets on the basis of emphasizing and proposing that hospitals go into early discharge programs, then early discharge programs will not be successful unless there is an agency such as Home Care to provide the level of care necessary at home that will allow early discharge to take place. If, on the other hand, the home care program is restricted funding-wise the same way as the hospital, ... [this] will result in no programs for patients to be discharged to... hospitals will have to maintain [them]... or discharge them much earlier without the quality of care they should normally expect to obtain."

Recommendations were for:

- patient surveillance (including overnight surveillance) support/assistance from trained personnel;
- palliative care in the home;
- more funding;

- the need to deal with impacts of future new programs such as Geriatric Day Hospitals, which have their own assessment and treatment functions, on the Coordinated Home Care Program;
- an in-depth evaluation of the program as a whole based on a cost-benefit analysis.

5.5.4 Metropolitan Hospitals

Nine briefs were received, three from Calgary and the rest from Edmonton:

* Foothills Hospital
* Rockyview Hospital
* Salvation Army Grace Hospital
* Charles Camsell General Hospital
* Cross Cancer Institute
* Glenrose Hospital
* Misericordia Hospital
* Royal Alexandra Hospital
* University of Alberta Hospitals

All hospitals VALUE and SUPPORT the program highly. They are integrally involved with the program, and Home Care staff work on site for varying lengths of time on a regular basis (e.g. 2 full time home care staff at one hospital which has 100-120 referrals per month).

The most frequent ACHIEVEMENTS noted for the program were CONTINUITY OF CARE upon early discharge, and early discharge itself (5 out of 9 respondents). Other achievements included increased quality of care due to a more appropriate environment, cost savings and better bed utilization.

GAPS in service were noted, with six respondents remarking on the need for homemaker services, and four hospitals pointing out the UNEVEN AVAILABILITY of services for the RURAL patients. Such patients account for an increasingly high proportion of the total caseload of many metropolitan hospitals (50% for the Cross Cancer Institute). The lack of services for MENTAL/ALCOHOLIC/MULTIPROBLEM PATIENTS was mentioned in 3 briefs. Two hospitals noted the need for SERVICES TO INDIANS from reserves living in the inner city.

A definite trend regarding future needs was not evident. A large number of different needs were identified. Some of these included:

- responding to a general increase in the demand for home care due to earlier discharges and the increasing elderly population;
- providing new, special care home services due to medical advances such as Home dialysis/Home TPN/Hickman catheters/Oncology treatments;
- providing care for persons with progressive neurological degenerative diseases and stroke patients;
- safety surveillance of those at highest risk (e.g. the frail elderly);
- counselling for the terminally ill and bereavement care; and,
- ensuring that home care is considered as an alternative to institutionalization for placement and referral.

RESPONSES to future needs were: provision of 24-hour nursing and homemaker services; increases in budgets; expansion of scope to provide comprehensive home care services; use of more social workers and contracted professional counsellors. One hospital brief called for the identification of the most vulnerable target population: the severely dependant. This target group would be cared for through a program administered directly by the province; others would be cared for through local programs.

Principal program STRENGTHS were its availability and apparent cost savings it generated. Willingness to accept late referrals, positive home care-hospital staff relations, a single agency focus for obtaining all services, were also mentioned by the hospitals.

The most common WEAKNESSES were restricted hours of service, the restriction to medical entries, budget limitations, and bureaucratic requirements (ranging from too much paper work, to cumbersome protocols and lengthy procedures to admit clients). Other identified weaknesses were:

- division of responsibility at the local level for medical versus social support programs;
- lack of a wholistic approach to care;
- overemphasis on short term care;

- limits to the time that patients can be on program;
- lack of trained nurses for caring for oncology patients; and
- division of the discharge/teaching function, from the function of setting up the home care service for a patient.

The most frequently mentioned REMEDY was the introduction of a SOCIAL ENTRY (5 out of 9 explicity, 2 more implicity). At least two hospitals recommended: enhancement or development of PALLIATIVE CARE, and the provision of home care to patients with IV MEDICATION needs (e.g. osteomyelitis patients needing a course of antibiotics) who otherwise have no reason to be in a hospital. The establishment of an APPEAL mechanism was specifically recommended by two hospitals.

Other recommendations:

- increased funding;
- ensure portability of home care benefits between provinces;
- enhance preventive aspect of the program;
- streamline program admissions;
- place medical and social entries under one jurisdiction to increase coordination and continuity;
- ensure a complete rehabilitation philosophy is implemented;
- continue review of the records system in the program;
- run a pilot project using different mixes of trained and untrained staff (including volunteers) to try to increase program cost effectiveness;
- seek out and try other models of home care as pilot projects (e.g. Manitoba Program/Five Hospital Homebound Elderly Program, Chicago/Ebenezer Community Services Home Care Program, Minneapolis/Hospital Home Health Care Program - for small rural hospitals - Albuquerque, New Mexico/Saskatchewan Program/support service systems for the elderly in Poland)
- review future needs on the basis of the 3 levels of home care defined by the American Hospital Association: intensive or "coordinated home care"/ intermediate or "rehabilitative level"/and basic health level or "minimal or basic care."

TABLE 5.2

A SELECTIVE SUMMARY OF ASSOCIATION BRIEFS

	ASSOCIATIONS REPRESENTING		
	SERVICE POPULATION INTERESTS N = 6	PROFESSIONAL INTERESTS N = 6	BROADER ISSUES N = 5
RESPONSES TO CHCP	Supportive	Supportive	Supportive but critical
MAJOR/TYPICAL ISSUES	Requirement for non-medical entry	Need to expand/include services of trained professionals (Registered: Dietitians/Nursing Aides & Orderlies/Occupational Therapists)	Program is of benefit to only those who are eligible Comprehensive program required
SECONDARY ISSUES	Comprehensive assessment of need by professionals Expansion of program scope	Expansion of program scope	Need for common jurisdiction /coordination Inadequacy of position of CHCP in the context of the health care system as a whole
OTHER	Gap in service is for permanently disabled persons with deteriorating conditions, and the frail elderly	Support for palliative care	Need for an evaluation rather than just a review Program is stabilizing and losing its vitality

Note: CHCP - Coordinated Home Care Program

5.6 ASSOCIATIONS - GENERAL

Seventeen briefs were received from associations. These were grouped into three categories. The first category represented the interests of special target groups who could be well served by home care, but currently had limited access to the program. The second category comprised briefs which recommended the inclusion or expansion of services provided by the membership of the various responding associations. The third category offered broader views, somewhat critical, on the program.

All briefs SUPPORTED the Coordinated Home Care Program, explicitly or implicitly. Each responding group also noted that current program services were RESTRICTIVE.

5.6.1 Associations Representing Specific Service Populations and Interests

Six briefs were received from the following associations:

- Alberta Committee of Consumer Groups of Disabled Persons
- Multiple Sclerosis Society of Canada, the Lloydminster Chapter, and the Edmonton Chapter - three in total
- Alberta Rehabilitation Council for the Disabled
- Society for the Retired and Semi-Retired of Edmonton

The common PURPOSE of the program seen by all associations was TO KEEP PEOPLE AT HOME and thereby avoid institutionalization. Associated purposes were to enhance independence, to facilitate faster recovery, and to involve the client/family in the recovery process, because the service was provided at home. The PREVENTIVE NATURE of home care, its viability as an ECONOMICAL ALTERNATIVE TO INSTITUTIONALIZATION for long term care were also noted.

ACHIEVEMENTS of the program were varied, with the PROVISION OF CARE being the most common, although two briefs added the qualifying phrase "for those that are eligible". The second most common achievements were: REDUCTION OF HOSPITAL STAYS; the improvement in QUALITY OF FAMILY LIFE (by keeping families together, involving them in care and support, and reducing guilt associated with disabilities); and IMPROVED FOLLOW-UP after discharge from hospitals or better management of long term illness.

The dominant SERVICE GAP for all associations was care for those not eligible for home care because they did not meet the medical entry criteria: (i.e., the PERMANENTLY DISABLED, those with DETERIORATING CONDITIONS, the YOUNG DISABLED and the FRAIL ELDERLY who could live at home with some extra help). One brief called for the provision of more FLEXIBLE HOURS OF SERVICE, with care being provided at the client's convenience rather than at the convenience of the provider agency.

FUTURE NEEDS tended to repeat current needs. Extra emphasis was given to 24-hour emergency service and flexible hours. RESPITE CARE for the families of clients was specifically noted in two briefs.

To meet these needs the Coordinated Home Care Program should RESPOND in many ways. The most frequently mentioned way was to establish a COMPREHENSIVE ASSESSMENT process carried out by professionals, and based on FUNCTIONAL NEEDS CRITERIA.

Apart from a restatement of many achievements, special STRENGTHS noted by individual associations were: the program is FREE (at least for its medical services); it is PROVINCIAL in its coverage; and, it is COMMUNITY BASED.

Program WEAKNESSES varied according to association, with one common theme being DISQUALIFICATION of those not meeting the medical entry criteria, and LIMITATION OF SCOPE of services. INCONSISTENT provision of support services by Local Health Authorities appeared as a weakness in two briefs. Budget issues and coordination problems associated with the division of responsibilities for health care between Social Services and Community Health and Hospitals & Medical care were each mentioned once.

REMEDIES were related to the interests represented by each association. NON-MEDICAL ENTRY to the Coordinated Home Care Program and to EXPANSION OF SCOPE (e.g. to include attendant care/transportation/home maintenance/etc.) were strongly supported. One association urged the program to promote consumer independence. Two groups called for an APPEAL PROCESS for resolving conflicts over admission to the program.

The following quotation serves to summarize the views expressed in this set of briefs:

> "In conclusion we would like to say that our organization recognizes the true and inestimable value of Home Care. We appreciate that a province-wide service was introduced and that it has made a very real difference to the lives of many... citizens of Alberta. We believe that it is timely now for the Province to take the next step, to extend the program so that it is a broader program of support for the [frail elderly/handicapped/those with deteriorating illnesses etc.] as well as for those who need the medical care provided by the present program."

5.6.2 Associations Representing Professional and Other Interests

Six briefs were received from:

* Hospice Care of Edmonton
* Lethbridge Volunteer Bureau
* Alberta Association of Registered Occupational Therapists
* Alberta Registered Dietician Association
* Alberta Association of Registered Nursing Orderlies
* Alberta Association of Registered Nursing Assistants

The briefs in this category partially overlapped with those in section 5.5.1.

Except for Hospice Care of Edmonton, all associations recommended the inclusion or expansion of services of formally trained persons belonging to their respective organizations (e.g. Registered Dieticians, Nursing Aides and Orderlies, and Occupational Therapists). The services of these personnel were seen to be necessary to meet the needs of the elderly (nutrition assessment and counselling); to ensure cost effectiveness through the substitution of more expensive, current service time for the less expensive services of their own membership (e.g. Nursing Assistants and Nursing Orderlies substituted for Nurses); and to facilitate recovery by providing more rehabilitation services (Occupational Therapists).

The associations in this group did not restrict themselves to areas of narrower self-interest. STRONG SUPPORT was offered for the Coordinated Home Care Program. The purposes, achievements, strengths and weaknesses cited in the briefs were comparable to those described in section 5.6.1.

SCOPE EXPANSION was supported directly or indirectly by most briefs (meals-on-wheels/personal care aides/psychiatric workers/social workers). Support existed for a NON-MEDICAL ENTRY. Two associations commented specifically on the need for greater program PROMOTION among the public, and physicians.

5.6.3 Associations Presenting Broader Program Issues

Five briefs were arbitrarily placed in this category, despite the partial overlap with section 5.5.2. The briefs received were from the:

* Victorian Order of Nurses (both Lethbridge and Medicine Hat Branches)

* Independent Therapists Ltd.

* Alberta Public Health Association

* Friends of Medicare

The respondents were SUPPORTIVE to the program, but commented on its achievements, within the context of services it has provided to date:

> "It [the Coordinated Home Care Program] has become a reality! It is fantastic! The Provincial Government should be highly commended for its inception of the provincially funded Coordinated Home Care Program."

> "The Alberta Coordinated Home Care Program is functional and meets a narrow range of needs very well, for those [who] are eligible."

> "The current program meets the needs of persons requiring short-term services following an acute illness. However, it is not presently able to prevent institutionalization -- either hospitalization or nursing home admission -- in most parts of the province. Additionally, it is useful for persons requiring the 'medical' services -- nursing and rehabilitation services -- but not for those requiring emotional or psychological support, nutrition counselling, minimal assistance with activities or daily living (personal care or chores), foot care, or monitoring."

The development of the program was critically viewed, however:

> "Home Care has not changed much over the past 3-1/2 to 5 years. Little creativity noticeable. Status quo maintained, little evidence of progressing into acute in-home care or caring, not curing, the elderly."

Program STRENGTHS were not reviewed by respondents in this category, although the tone of the letters was supportive to current services. The weaknesses identified appeared to be presented to facilitate changes in the program, or to make it more effective, rather than to demonstrate non-support.

Some of the WEAKNESSES identified by respondents are exemplified by the following comments:

> "Lack of emphasis on prevention. Put health back into health care."

> "Conflict between financial capabilities and service needs."
>
> "Emphasis on control rather than coordination."
>
> "Potential loss of physician income if Home Care is used widely in a rural setting. This interferes with the Home Care acceptance."
>
> "Failure to provide services universally, i.e. all age groups."
>
> "Disproportionate amount spent on superstructure."
>
> "Inconsistencies...in new record system being implemented - both in terms used and codes used."
>
> "Duplication of paperwork."
>
> "Duplication of services regarding assessments."
>
> "Lack of coordination between the Department of Hospitals and Social Services and Community Health has led to some difficulties in providing a continuum of care for Albertans....Information flow between home care and hospitals can be hampered by regulations on confidentiality which would be different if home care and hospitals were supported by the same administration....Referral to Home Care gives no advantage to the Department of Hospitals as no savings are apparent....The provision of care is less smoothly handled for this same reason, e.g. admission to and discharge from nursing home, admission to and discharge from auxiliary hospital, admission to and discharge from an active treatment hospital and admission to and discharge from Home Care is not facilitated."

The limitation of hours of service in the program was linked by one association directly to unecessary institutionalization:

> "Members of our elderly population are still being forced to enter or remain in institutions inappropriately. This result in loss of morale, physical and mental deterioration, and excessive costs. One of the reasons for inappropriate institutionalization is the limitation of many services to a 9-5 weekday schedule."

FUTURE NEEDS included:

> "Expertise in dealing with multiple handicaps children and adults as de-institutionalization proceeds and institutionalization becomes less acceptable."
>
> "As the geriatric population increases (in 1996 - 11.5% of Canadians will be more than 65 years, 8.6% in 1981) expertise in geriatric care will be needed. The care will be related to aging, not the acute medical care now delivered. Aging is not a disease in that there is no cure, but care is needed."
>
> "Special services to coordinate, supervise and instruct family and clients on home dialysis, total parental nutrition, pre and post day surgery procedures."

A range of REMEDIES were suggested:

> "Review the philosphy of caring. Review the cost of institutional care, not only in terms of finance but also in terms of quality of life for clients. It is really a matter of what we can do with (along with) a person rather than what we do for or to him."
>
> "Change eligibility criteria re: non-medical services, group homes, nursing homes....[Develop] Cooperative interaction between the Department of Hospitals and Medical Care and Social Services and Community Health to greater utilize Home Care Programs....Consider Long Term Care Ministry. Set goal to decrease Home Care Administrative costs and thus increase service resources."

Three of the five briefs commented on THE DEGREE OF INSTITUTIONALIZATION in Alberta. As one association remarked:

> "We are concerned about Albertan's overreliance on institutions as the mode of delivering acute and chronic, short-term and long-term, care for all age groups."

A MORE DETAILED ASSESSMENT of the program was suggested by three responding groups.

> "We are concerned that this review process does not constitute a full-scale research based evaluation of the Alberta Coordinated Home Care Program."
>
> "A proper and thorough investigation might well reveal significant cost savings resulting from use of appropriate home care services in lieu of more costly hospital and nursing home use."

One of the two associations calling for a more intensive study of the program suggested that the Coordinated Home Care Program be reviewed using the original principles underlying the development of the health care system in Canada, (i.e. that the criteria for assessing the current Coordinated Home Care Program be ACCESSIBILITY, COMPREHENSIVENESS, UNIVERSALITY, PORTABILITY). Doubt was expressed that the program would satisfactorily meet these, as it should, as an integral part of the health care system.

5.7 MISCELLANEOUS SUBMISSIONS

Three letters were received from villages and towns: Evansburg, Holden and Olds. The Evansburg letter recommended expanding the present definition of medical need "to include these citizens who by infirmity or old age require assistance in one form or another, but do not meet the present definition of 'medical need'."

The Village of Holden remarked on the special value of Home Care to the community in the absence of a hospital or local physicians. The benefit of being able to obtain care while at home or in the local Senior Citizens Lodge and self contained units was also cited.

The Town of Olds informed the study that while it had participated in the program previously, the contract between Home Care and the Olds Homemaker Service has not been renewed. Accordingly, no comments were provided on the program.

Three Local Health Authorities submitted written responses as a follow up to previous interviews. Two of these were from rural parts of "mixed" districts and one from an urban centre.

The three letters expressed the PURPOSE/ACHIEVEMENTS of Home Care as: permitting patients to stay in their own homes and reducing bed use in institutions, particularly where there was limited bed availability.

Other program purposes identified were: providing care to terminally ill patients at home; involving families with care; and providing advice on Alberta Aids to Daily Living services. Other ACHIEVEMENTS of the program were: its growing acceptance by the public and physicians; the increased service availability and coverage; and in one case, the development and continuation of a palliative care program.

A FUTURE NEED identified by the urban unit was for more home help for cancer patients and/or young children.

Several STRENGTHS of the program were noted in the three letters from the Local Health Authorities. One "mixed" unit noted the special value of the Home Care Management Committee despite its non-acceptance by the Board. The writer feared for the future of the Coordinated Home Care Program if the Committee were dismissed. Other strengths noted were the smooth running of the program and its solid profile in the community. Strengths identified by the urban unit were: group cooperation; effective implementation of the team concept among Home Care staff; and the provision of care to people in their own homes. A "mixed" unit listed the following as strengths: the successful management of clients of all ages in their own homes; the control clients had over the management of their own care plans; the excellent calibre of the Home Care staff; and the accessibility of workshops and inservices for program staff.

WEAKNESSES noted by the Local Health Authorities were:

- a lack of rehabilitation therapists;
- income determination process which places a strain on program/client relationships;
- a lack of coordination and program awareness between hospital/doctors/Home Care staff resulting in incomplete case histories or late treatment;
- a lack of funding, particularly associated with homemaking (all three letters);
- "the massive amount of paper work"; and
- an identification of the home care program with nursing care, at the provincial and local level.

CHAPTER 6: PUBLIC MEETINGS

6.1 CHAPTER OVERVIEW

The purpose of this chapter is to summarize the proceedings of 13 public meetings held throughout Alberta for the review. Section 6.2 highlights the major issues discussed across all meetings. Subsequent sections describe each meeting in greater detail.

6.2 PROVINCIAL SUMMARY

Table 6.1 below provides a brief summary of the most frequent responses at public meetings.

TABLE 6.1

Summary of Most Frequent Response at Public Meetings

QUESTION CATEGORY	RESPONSE
ACHIEVEMENTS	To keep people at home
SERVICES GAPS	No social entry
FUTURE NEEDS	Expanded services to eldery Mental Health counselling
RESPONSES TO FUTURE NEEDS	Increased funding Public education
STRENGTHS	Staff qualities Coordination
WEAKNESSES	Insufficient public awareness Fee issues
REMEDIES TO WEAKNESS	Increased funding

The attendance at the 13 public meetings varied greatly both in number and affiliation of those in attendance. There were less than 10 persons at each of 5 meetings, between 10 and 25 persons at 7 other meetings, and up to 50 persons at the remaining 2 meetings. (Two meetings were held in Vegreville - one in the afternoon and one in the evening, at the community's request.) Some meetings were primarily attended by clients and family members; others primarily by Board members or staff. However, taken over all 13 meetings and 1 workshop there appeared to be a fairly equal representation of clients, interest groups/associatons/agencies and Board/staff members. In addition, members of the public at large and representatives of institutions such as hospitals, nursing homes and lodges attended many of the meetings.

The following summary represents primarily the views of the general public, groups or associations, and clients, rather than the views of the Home Care Program staff members who attended.

The most significant ACHIEVEMENT of the Coordinated Home Care Program according to the majority of those who attended the public meetings, was to enable people, primarily the elderly, to remain in their own homes or Senior Citizens Lodges. Many clients or family members also made positive comments about the palliative care program, early discharge services and the effective manner in which community needs were met.

With respect to GAPS in service, the primary topic of discussion at most public meetings concerned the lack of access to support services without a medical need, particularly by the elderly and the disabled. Given the major perceived purpose of enabling people to remain in their homes, it was felt that lack of social entry was a serious barrier to achievement of this purpose, particularly in areas where no Family and Community Support Services programs existed. The second most frequently discussed gap in service was an insufficient level of service for specific purposes, for example, 24 hour, 7 day per week service for respite or palliative care. The lack of adequate mental health services was mentioned in several meetings, with any remaining service deficiencies discussed at only one meeting.

Although discussion regarding future needs and requirements did not occur at all public meetings, in those meetings where the topic did arise, the most frequently mentioned FUTURE NEEDS were expanded services for a growing elderly population, mental health counselling, and expanded palliative care and rehabilitative services. Responses to future needs concerned increased funding and public education with the occasional mention of more coordination and more volunteer services.

A wide variety of program STRENGTHS were identified. Roughly in order of frequency, major strengths included: staff abilities and commitment; the single focus the program provides for coordinating all client services; high quality assessment and hospital discharge planning; relief of stress on families; continuity of patient care; service to lodge residents; the volunteer component; and cost effectiveness.

The major WEAKNESSES of the Home Care Program were perceived to be: lack of public awareness of the range and criteria of services; confusion over the fee schedule; inadequate transportation; lack of coordination between Alberta Hospitals and Medical Care and Alberta Social Services and Community Health; and, lack of adequate incentive to use home based rather than institutuional care. Actual or impending budget restrictions were also of considerable concern.

Relatively few REMEDIES to the above weaknesses were proposed. Remedies and recommendations most frequently mentioned include: increased funding; implementation of a broadened entry to the program; extension of hours of service; increased volunteer involvement; and, implementation of a public advertising or educational campaign to better inform Alberta residents of the Coordinated Home Care Program.

The overriding theme observed in the public meetings was A SINCERE APPRECIATION OF THE EXISTENCE OF THE PROGRAM by former and existing clients or family members, members of associations or agencies, and institutional representatives alike and AN EMPHATIC WISH THAT THE COORDINATED HOME CARE PROGRAM CONTINUE TO PROVIDE NEEDED SERVICES.

6.3 EDSON

Date: December 7, 1982

Attendance: Approximately 20

The meeting was attended by existing and former clients and their family members; representatives of client groups such as senior citizens and the handicapped; local hospital, nursing home and Senior Citizens Society representatives; and interested residents of the Edson area, some of whom were members of the Home Care Management Committee. Several Health Unit staff also attended primarily as observers.

The response of existing and former clients was generally very positive but full consensus by other attendees on the ACHIEVEMENTS and impact of the Home Care Program was not reached. Many clients and other members of the public commended the program for keeping people out of hospital and other institutions, providing high quality of care and supporting family members. However, a negative impact on the local hospital/nursing home facility was the unanticipated reduction in demand for the new nursing home beds, and an increased need for auxiliary hospital beds not presently available in the community, due to the higher level of care required by persons who had remained at home longer on home care. Senior Citizens representatives felt that the achievements of the program to date were inadequate, due to the high rate of institutionalization of the elderly and the perception that provincial government departments affecting this issue lack an articulated coordinated policy on health and social services for the elderly.

The major SERVICE GAP was the lack of access to any support services in the Edson area without admission to home care. A Family and Community Support Services program had just been initiated in Edson but there was some opposition to providing support services under both organizations; instead, expanded eligibility for home care was favoured. Lack of public awareness of available services, confusion regarding the fee schedule, the role of home care compared to other social services, and high travel costs in large Units were considered WEAKNESSES of the program.

Identified STRENGTHS of the program included staff abilities, access to information on preventive and new methods of care, and valuable assistance to residents of the local senior citizens' lodge. In future, with the help of increased funding, it was suggested that increased rehabilitation, preventive, and counselling services would be appreciated. Also, it was stated that due to the growing number of seniors in the area, either an increased level of home care or hospital services will be essential.

6.4 HANNA

Date: November 24, 1982

Attendance: Approximately 12

The majority of persons at the meeting, which was held on a particularly cold evening, were Health Unit Board members or Home Care Program staff who had been interviewed earlier the same day. Thus, many of their comments were not repeated at the public meeting. One attendee had been involved with the program from a user perspective.

The major ACHIEVEMENTS of the program were felt to be: keeping persons out of nursing homes and in their own homes or self contained apartment units (as shown by a shorter nursing home waiting list); and providing home based palliative care with support to the family.

Aspects of the local Coordinated Home Care Program program which were termed STRENGTHS were: volunteer activities especially those involving senior citizens; the opportunity for Home Care staff to assess client's needs in the home and liaise with physicians; and the ability to serve the special needs of rural residents (e.g. assistance with home dialysis).

The major WEAKNESSES of the program were: barriers to its development: reluctance to use home care especially for younger patients due to low occupancy in local hospitals; an inadequate awareness of the range of services available; and the restrictive criteria for admission and "staying on" the program. The physician who attended stated that there was insufficient awareness of the Alberta Aids to Daily Living and Extended Health Benefits Programs.

In future, the program will have to respond to the needs of a gradually growing elderly population and a possible increased demand for palliative care. The need for more acute care hospital beds in this rural area was questioned. Finally it was agreed that in a period of recession and limited budgets, priorities must be set so that those who need home care most get it, and that there should be an increased emphasis on family and volunteer involvement.

6.5 ATHABASCA

Date: November 25, 1982

Attendance: 3

Due to inclement weather and a competing Town planning meeting, attendance was poor. The Home Care Coordinator, President of the Senior Citizens group, and local press reporter were present.

Comments about Coordinated Home Care Program were positive, citing "favorable comments" from clients of the program. Home nursing, Homemaking and Meals on Wheels were felt to be good services. If there was any WEAKNESS in the program, it was lack of public awareness about the program (as the poor turnout at the meeting possibly demonstrated).

6.6 HIGH RIVER

Date: November 1, 1982

Attendance: Approximately 35

Due to its location in the High River Senior Citizens' Friendship Centre, the meeting was attended primarily by seniors, many of whom had no previous contact with the Home Care program. In addition, other members of the community and a delegation of Board and Administration from High River Hospital participated in the meeting. Some Home Care staff members attended as observers.

While it was agreed at the outset of the meeting that the Home Care program had helped "old people stay home longer" and assisted people following surgery, the meeting generally served as a forum for discussion of the weaknesses and other issues concerning the program.

There was a great deal of discussion regarding the differing need for and regulations concerning medical needs versus social needs. It was observed that, because no Family and Community Support Services programs existed in the area and because the Home Care Program now is restricted to medical entry, many elderly people are not being served optimally and several have been forced to go to nursing homes due to support services deficiencies. Specific GAPS in services included Handyman services for heavy work in spring and fall, and podiatry services.

Financial aspects of the program were considered one of its main WEAKNESSES. It was stated that the fee schedule was "too complicated" and should be simplified. There was also a great deal of confusion regarding the "two week limit", the entrance criteria, other regulations, and the possibility of the Home Care Program "budget running out". It appeared to some people that the Home Care Program began with "fanfare" and money but that funds were decreasing and less emphasis was now being placed on the program by government. The hospital's concerns centered on the need for home care to respond to the increasing shortage of acute care, nursing home and auxiliary hospital beds. It was stated that 12 patients now in nursing home and auxiliary hospital beds could be discharged if the home care entrance criteria was changed to allow social entry. In addition, surgical bed utilization could be increased if there were 7 day a week Home Care coverage instead of 5 days. In addition, funding might be more reliable and hospital input increased if Home Care was transferred to Alberta Hospitals and Medical Care. Other attendees suggested that the lack of 7 day a week Meals on Wheels service was preventing its full usage by seniors.

During the meeting, the following STRENGTHS of the Home Care Program were mentioned: the hospital's appreciation of support during a recent hospital nurses' strike; the excellent relationship between the program and the hospital; and the volunteer aspect of the program especially many Meals on Wheels.

6.7 REDWATER

Date: November 29, 1982

Attendance: 22

The meeting was attended primarily by clients and/or family members, with some Family and Community Support Services and hospital representation.

Many favourable comments about Home Care and its staff were made by clients during the meeting and most were anxious to see the program continue.

It was agreed by all present that Home Care's major ACHIEVEMENT has been that it has enabled many people to stay in their own homes longer. Other accomplishments included: earlier discharges from hospital; provision of in-home equipment (respirator); and, the sense of security enjoyed by clients.

NEEDS which are not presently being met derive from an insufficient quantity of service per client due to travel time and inefficient staffing.

FUTURE NEEDS were identified as an early maternity discharge program, psychiatric services, and dressings and supplies coverage. Increased public and staff education on Home Care was also suggested for the future.

Current program STRENGTHS mentioned by individuals included hospital discharge planning, ability to refer to other agencies, cost-effectiveness, and promotion of self care.

Several persons agreed that the medical entry criterion restricting access by the elderly was a major WEAKNESS. Other weaknesses included lack of homemaking in one community, inadequate transportation, lack of public awareness (many people "do not know what is available through home care") and, according to the Family and Community Support Services representative, lack of coordination between the Home Care and Family and Community Support Services Programs. Recommendations for improvement included broadened entry criteria, coordination of fee structures, public advertising campaign, professional education, and consolidation of Home Care, Hospitals, and Family and Community Support Services in one government department.

6.8 VEGREVILLE #1

Date: November 29, 1982 (2:00 p.m.)

Attendance: 14

Several members of the group represented Home Care Management Committee and staff. Others included representatives of other agencies, such as the Senior Citizens Lodge and Services for the Handicapped, and the public at large.

Those attending the meeting were generally very supportive of the program, calling it "wonderful", and one individual noting that "no one is willing to part with it."

ACHIEVEMENTS of the program included: enabling people to remain in their own homes where they are happier; letting people stay longer in the lodge rather than going into a nursing home; letting older couples stay together longer; and, providing a more economical service. While the program is primarily benefitting senior citizens, some younger handicapped persons are also making use of it.

Current service GAPS identified were: insufficient transportation and other support services (especially in areas without Family and Community Support Services); lack of knowledge of the program by some potential clients; and in some cases refusal of service by very "independent" persons.

Transportation was discussed at some length as a FUTURE need that should be made available to more people. Also, people with "mental" problems should be getting services, at least visits to offset their loneliness. As the population of elderly increases, needs for such services will expand.

It was felt that more public awareness is needed, more coordination with other agencies (Mental Health, Alberta Aids to Daily Living, etc.), and more emphasis on development of volunteer services (transportation and friendly visiting) is required to RESPOND to current and future needs.

STRENGTHS of the program included involving volunteers in service delivery involving the community, and giving clients a sense that someone "cares." The staff "deserve a bouquet" for what they have achieved.

WEAKNESSES, in addition to problems mentioned earlier, included lack of social entry, paperwork, fee schedules, lack of office space for nurses, and lack of incentives to physicians to refer.

A request and recommendation was made that the results of the review be made publicly available.

VEGREVILLE #2

Date: November 29, 1982 (7:30 p.m.)

Attendance: 8

In addition to the Director and Coordinator, the audience consisted of several people from Tofield Hospital, a nurse from the Vegreville Hospital and a couple from Mundare.

In response to the question "How well is the program doing?" attendees commented that it was "Good", "Fine", a "Good job".

ACHIEVEMENTS of the program are: enabling people to remain in lodges rather than going into nursing homes; reducing the trips people have to make to the hospital for therapy and dressings; and facilitating early discharge from hospital.

Some people are not receiving adequate services, especially those with mental health problems. These might increase in the future.

STRENGTHS of the program were: good relationship with the hospital on discharge planning, coordination of services such as Meals on Wheels, the complementary roles of Community Health and Home Care, and generally a team approach.

WEAKNESSES primarily revolved around the lack of funding to permit further expansion of services to areas not presently being served, specifically to provide support services in areas without Family and Community Support Services, and to provide rehabilitation services.

6.9 WETASKIWIN

Date: December 6, 1982

Attendance: 12

The majority of persons who attended the meeting were former or existing clients or their family members. Three Health Unit staff members attended, primarily as observers.

In general, all attendees felt Home Care was "a very good program" which is "doing a wonderful job" but that it "needs expanding" and Government should "ensure good service across the province."

Among the ACHIEVEMENTS of the Home Care program specified was that it has enabled many elderly residents to stay at home in familiar surroundings with better care rather than having to be admitted to, or stay longer in, institutions. One former client stated "if the program wasn't available, I would have been in hospital much longer", and according to another, "I'd rather stay at home." Other achievements included the involvement of families in care, and the provision of needed services to rural communities.

It was generally agreed that the few WEAKNESSES and GAPS in service which exist such as insufficient homemaker services for respite care, insufficient Nursing staff and inadequate geriatric, surveillance coverage could be REMEDIED with increased funding, increased family involvement and a possible change in admission criteria to allow social entry.

According to the clients who were present, the major STRENGTH of the local Home Care Program was the dedicated and committed staff. Comments included the following: "staff are friends not just nurses", "staff work above the call of duty" and are "really concerned about people". The location of the program in the Health Unit was also considered a strength.

6.10 EDMONTON

Date: December 1, 1982

Attendance: 22

The primary participants in the meeting were representatives of special client interest groups (e.g. senior citizens, handicapped, multiple sclerosis), provider agencies, and a professional association. Several individual Home Care clients/family members also attended.

Overall most participants expressed appreciation of both the program itself and the review.

During a discussion of ACHIEVEMENTS it was agreed that the program has: allowed patients to be at home and to remain independent; strengthened and relieved stress on families; coordinated a range of services, including homemaking and rehabilitative services; and saved health care dollars as compared to institutional care. Several clients or their representatives described personal experiences in which Home Care was greatly appreciated including one involving a terminally ill child. It was noted that previous to the implementation of Coordinated Home Care Program, home care services were available to people in Edmonton through a joint City Social Services/Board of Health program.

The major service GAP identified was the inaccessibility to the program by the elderly, the disabled, and persons with chronic degenerative illnesses who need support services to function in their own homes but who do not require the medical or rehabilitative services which are stipulated by Home Care. The previous joint program did not have this restriction and thus it was felt that "something had been lost". Anticipated FUTURE NEEDS include long term rehabilitation services, respite care, and a counselling component for clients and families receiving other services.

Major identified WEAKNESSES of the Home Care program were: restricted hours of service; lack of continuity of care; insufficient coordination with Family and Community Support Services; the use of overqualified staff for some services; insufficient transportation; lack of nutrition education; fee structure confusion; and insufficient public education. In addition it was emphasized that incentives to use institutional care rather than Home Care should not exist and that having several different government departments involved in health care impedes communication.

REMEDIES to the above weaknesses include expanded public education, consolidation of government functions, improved training and education, and standardization of the range of services offered throughout the province but maintaining local administration. It was suggested that other provinces and countries could provide valuable models on home care delivery. Furthermore many attendees agreed that the current system of health care needed to move away from institutionalization and an illness orientation, towards a home care and wellness orientation.

6.11 FORT MCMURRAY

Date: November 22, 1982

Attendance: 7

Participants in the meeting, with the exception of a local newspaper reporter, all had some involvement with the Home Care as Board, Management Committee, Administration and nursing staff representatives. The discussion tended, therefore, to represent points of view that were voiced in individual interviews held prior or subsequent to the group meeting.

It was generally agreed that Home Care was "doing well" had been an asset to the community, particularly if it allowed seniors to remain in their own homes. (Fort McMurray has no extended care beds). The palliative care program was singled out as an ACHIEVEMENT.

The following groups of people were not being adequately served: persons who do not have an Alberta Health Care Insurance Number; Treaty Indians; and persons lacking a medical entry. Among the latter, a special group who could use Home Care were younger families having mental health difficulties, e.g., some "young moms" requiring assistance following psychiatric treatment.

With respect to FUTURE SERVICE requirements, "more of the same" will be needed plus additional palliative care. Increased funding and changes to the Regulations would be required. Improved liaison with Mental Health Services might also help.

STRENGTHS of the program were: staff who have pioneered in providing needed services; and the joint Health Unit and Hospital Board which encouraged the Hospital to make use of Home Care for early discharge and as an alternative for extended care patients.

WEAKNESSES included: lack of funding to meet existing demand: and confusion between fee schedules for Home Care and Family and Community Support Services.

6.12 GRANDE PRAIRIE

Date: November 8, 1982

Attendance: 4

As had been anticipated due to weather conditions, attendance at the meeting was nominal. The audience included the Home Care Coordinator, a member of the Management Committee (representing Senior Citizens), and two members of the public, including one from Beaverlodge.

The thrust of the discussion was that Home Care had met a community need where it has been implemented. The clientele benefitting most from the program were senior citizens wanting care in their own homes. One key to the success of the program was the involvement of the community in taking the initiative in developing and supporting the program. Another, related STRENGTH of the program was its emphasis on coordinating services, so that a person in need could access services from one place rather than go "hither and thither".

Not all communities, nor all people within the Health Unit were served by the program. Some communities such as Valleyview, Wanham/Eaglesham and Woking were not served. This was due primarily to insufficient funding for the program, since the Health Unit delayed one year in implementing the program. Furthermore, it was extremely difficult to serve those communities which have no Family and Community Support Services.

It was agreed that with adequate funding and the growth of awareness among the public and medical profession, the program will be able to meet an increasing demand from a growing senior citizen population in the rural areas.

6.13 LETHBRIDGE

Date: December 13, 1982

Attendance: Approximately 50

The meeting was very well attended despite severe winter weather conditions which prevented many persons from attending including representatives of disabled groups. (Note: The latter prepared a brief which was incorporated into Chapter 5 of this report). The group which participated in the meeting consisted of clients or their families, other interested citizens, and representatives of provider agencies, nursing homes, and hospitals.

From the comments made, the local Home Care program has a high profile in the community and appears very well accepted. According to one client, "I don't know how we managed before the Home Care program". Other ACHIEVEMENTS include: improved quality of life for clients; good coordination of services which has contributed to improved discharge planning and liaison with hospitals; improved assessment of patients; and increased continuity of care.

It was generally agreed that the major GAP in current services to local citizens, particularly the elderly, was the lack of sufficient personal care and support services without medical need to enable more people to remain in their own homes. In addition, there was no home based palliative care program (although an inpatient service is being developed) nor were there sufficient follow-up services for teenage mothers. FUTURE NEEDS included: expansion of rehabilitative services; increased teaching to promote self and family responsibility; increased emphasis on early discharge programs due to hospital bed pressures; counselling for grieving and addiction; and 24 hour/7 day a week services is selected cases.

Among the many STRENGTHS of the program discussed were the well qualified and capable staff, the team approach, initial funding, and the program's flexibility and responsiveness to the needs of individuals and the community. The location of the Home Care program in the Health Unit was also considered a major strength.

Many of the WEAKNESSES of the program appeared to derive from funding and fee schedule issues (e.g. the "fear of funding restrictions"). While it was agreed that the fee schedule structure was confusing and needed review, there was no concensus on the appropriate solution. Many were in favour of some form of payment or donation, some advocated standardized fees with Family and Community Support Services, and others felt that there should be no charges at all for services in order to be consistent with the hospital approach. A significant concern was the lack of funding to meet existing demands for services. Another weakness raised was the danger that some clients such as the "confused and forgetful", may be maintained at home inappropriately. The lack of information on cost comparisons, and the lack of portability between provinces were also perceived to be problematic.

In order to REMEDY the existing weaknesses and address the service gaps, the group recommended increased funding, addition of palliative care, broadened entry criteria (social entry), expanded hours of service, and recognition of Home Care as an integral part of the Health Care System One remedy proposed was the transfer of funds from the hospital to the Home Care sector.

6.14 MEDICINE HAT

Date: December 6, 1982

Attendance: 6

With the exception of two persons, those who attended the meeting represented provider agencies or staff of the Medicine Hat Home Care program, and were subsequently interviewed by RMC during the visit to the Health Unit. Thus, some of their comments duplicate those made in the interviews. Of the remaining persons, one lived in the Medicine Hat Community and had been active on a health facilities committee; and one, who provided comments immediately following the meeting, represented the administration of the Medicine Hat & District Hospital.

As background to the implementation of the Coordinated Home Care Program in 1978 it was stated that the Southeastern Alberta Health Unit had (and still has) a very high proportion of residents over 65 and a high proportion in institutions. The hospital set up and operated a home nursing program since 1973 along with the Victorian Order of Nurses in Medicine Hat. The ACHIEVEMENTS of the Coordinated Home Care Program which were mentioned include the coordination of a wide range of services, geographic expansion, and service to "people who fell through the net" of other agency mandates. It was agreed that many clients (primarily elderly) have been able to stay in their homes, and others have chosen to die at home.

GAPS in access to needed services occur in Redcliff, Bow Island, and scattered rural areas in which there is no Family and Community Support Services program. Thus, residents who lack a medical need for Home Care cannot get support services in order to remain at home. However, it was generally agreed that a "social entry" to Home Care would be "too open to abuse"; instead Family and Community Support Services development across the province should be encouraged. Other needs not currently being met were services to young handicapped, services to rural areas, and 24 hour intensive care for geriatric respite.

STRENGTHS of the Coordinated Home Care Program included: minor services to persons in Lodges which allow them to function at that level of care; excellent relationships among agencies ("Victorian Order of Nurses is smiling"); good liaison with area hospitals; and continuity of care for patients throughout the health care system.

Inconsistencies and inequities in the fee schedule (e.g. rates higher for clients on Home Care than Family and Community Support Services alone), poor liaison with Calgary hospitals, insufficient physician involvement due to their fee schedule, and difficulties in finding volunteers were considered WEAKNESSES. A longstanding local issue concerned the strained relationships between the Health Unit Board, Medical Officers of Health, Home Care Program, and Hospital. One person felt the program was not as effective or cost efficient as it could be. However, it was generally agreed that the Coordinated Home Care Program could/should remain under the jurisdiction of the Health Unit with some changes.

In future, it was felt more funds would be required to meet existing and FUTURE NEEDS, respond to the trend toward home palliative care, and potentially implement an early maternity discharge program as hospital bed occupancy increases. All in all it was agreed the Coordinated Home Care Program was a "super program".

6.15 RED DEER

Date: December 8, 1982

Attendance: 20

Participants in the meeting represented a cross-section of the public, including Home Care representatives, a lodge matron, Family and Community Support Services representatives, senior citizen groups, and clients of the program.

ACHIEVEMENTS of the program include: keeping people in their own homes and providing home services to the terminally ill. Special attention was drawn to the sense of caring provided by the nurses, essential to alleviating the loneliness experienced by many senior citizens. At a recent "testimonial" to Home Care, many clients attended and expressed their appreciation of the nurses "Doing Small Things with Great Love."

Some participants felt that some people were not receiving all the services required due to GAPS in the program. In particular, those requiring help at night or on weekends and those suffering depression and loneliness were not being served. These needs might be met through development of Volunteer programs for visiting and evening/weekend assistance.

STRENGTHS of the program were: coordination of community services; relief for primary care givers (family); and a caring committed staff.

WEAKNESSES identified were: insufficient funding to provide optimal homemaking services, problems/confusion with the fee schedule; lack of social entry for those who are depressed, lonely or who require assistance to prevent deterioration and hospitalization; and lack of 24 hour/7 day per week services.

The group expressed interest in the plans for distribution of the results of the review.

6.16 CALGARY HEALTH SERVICES HOME CARE WORKSHOP

Date: October 16, 1982

Attendance: 68

The Home Care Management Committee held a full day workshop as part of its internal evaluation of the Home Care program. Representatives of boards and staff of public, private, and voluntary health and community service agencies were invited to discuss the Calgary Health Services Home Care program as it has developed to date, its current limitations, and where it should be headed in the future. Prior to the workshop, prospective attendees were requested to complete a questionnaire to be used during the workshop and in the preparation of a brief to Government from the Home Care Management Committee.

The discussions focused on the identification of groups or areas where Home Care services are not currently provided or not provided at a sufficient level. Areas of most concern to those present were the restrictiveness of the medical entry primarily in accommodating the needs of the elderly and the disabled, inadequate mental health services, inability to provide 7 day a week, 24 hour services when needed e.g. for respite, and inadequate public and physician awareness of the Home Care program.

The major conclusion of the Workshop was that the current deficiencies of the Coordinated Home Care Program could be remedied through the following measures: increased funding; broadened eligibility criteria/functional entry; demonstration of the cost-effectiveness of the program; addition of nutritional services; and separation of the Coordinated Home Care Program budget from that of the Health Unit at the local level.

CHAPTER 7: ASSESSMENT AND PLACEMENT COMMITTEE MEMBER INTERVIEWS

A total of 32 telephone interviews were held with institutional representatives of District Assessment and Placement Committees.

Of the 32 representatives interviewed, 19 (59.4 percent) indicated that there was no representative of the Coordinated Home Care Program on the Assessment and Placement Committee in their area. Twelve (37.5 percent) did have a representative, and 1 (3.1 percent) did not know. Several of those in the "no representative" group commented that although there was no permanent representative on the committee, Home Care staff were invited to attend when home care clients were involved, or as observers. In two areas, permanent representation was being considered.

In response to the issue of whether or not home care was considered as an alternative to institutional placement, 23 (71.9 percent) replied in the affirmative, 7 (21.9 percent) replied "no" or "not appropriate"; and 2 (6.3 percent) did not respond. Frequently, respondents commented that good relationships existed between the Home Care Program and the institutions represented, that home care was considered as the first choice whenever possible, and that the incentive for relying on home care was provided by bed shortages. In one community, home care was utilized for auxiliary patients on home passes.

Many of those respondents who stated that home care was not considered as an alternative to institutional placement felt most patients required a higher level of care than home care could provide.

In response to the question of whether or not home care had any effect on the length of the waiting lists for auxiliary hospital and nursing home placement, 20 (62.5 percent) replied "yes" (decreased length of waiting list), 9 (28.1 percent) replied "no" (no effect), and 3 (9.4 percent) had an "other" reply.

Many respondents commented that, while the length of waiting lists had decreased in length, applicants on the list required a much higher level of care than they did previous to home care. Many commented that home care has definitely enabled people in their area to stay in their own homes or Senior Citizens Lodges longer, but in some cases, a long waiting list still existed. Respondents who noticed little or no waiting list reduction commented that, in fact, they had very long waiting lists, and that in some cases, their area was poorly served by home care. One respondent commented that home care was "identifying new people who need services" and, as a result, was not decreasing the waiting list.

APPENDIX A

HOME CARE PROGRAM REGULATIONS

THE HEALTH UNIT ACT

Home Care Program Regulation

1 In this regulation,

(a) "Act" means The Health Unit Act;

(b) "board" means the board of a health unit appointed under the Act and includes a local board of health;

(c) "committee" means a home care management committee established under section 3;

(d) "co-ordinator" means a home care program co-ordinator appointed under section 6;

(e) "home help service" means routine housecleaning, laundry, ironing and meal preparation;

(f) "homemaker service" means the service provided by a homemaker and includes

(i) personal hygiene care and assistance with activities of daily living,

(ii) household management, marketing, meal preparation, house cleaning and laundry,

(iii) child care during the absence or incapacity of a parent,

(iv) emotional support,

(v) teaching child care, care of the ill and household management, and

(vi) activities delegated to the homemaker by a homecare nurse or rehabilitation therapist and that are supervised by a health professional;

(g) "program" means the home care program;

(h) "support services" include homemaker service, home help service, handyman service, meals on wheels, wheels to meals and transportation.

2(1) A board may submit a home care program to the Minister for approval and if that program is approved, the board shall, out of grants provided by the Minister for the purpose, provide the program in accordance with this regulation.

(2) The program shall provide home care services and the board shall co-ordinate with other agencies providing similar health and support services.

(3) A home care program shall include

(a) home nursing services, and

(b) homemaker or homehelp services.

(4) A home care program may include

(a) physiotherapy, speech therapy, occupational therapy, respiratory therapy, dressings, drugs, biologicals or other related preparations, or the use of any of the medical equipment listed in Schedule 1, or

(b) handyman services, meals on wheels, wheels to meals, or transportation services.

(5) The board shall, in providing a program, utilize volunteer services to the fullest extent possible.

3(1) In order to provide a program in accordance with section 2(1), a board shall establish at least one committee and shall appoint to each committee

(a) one person representing the hospital, auxiliary and nursing home districts and hospital boards within the board's health unit or health district, as the case may be,

(b) one person representing the preventive social services boards within the board's health unit or health district, as the case may be,

(c) at least one person representing the board,

(d) a physician engaged in private practice within the board's health unit or health district, as the case may be, and

(e) not more than 7 persons, who are either providers or consumers of home care services, or citizens at large, residing within the board's health unit or health district, as the case may be, and participating in the program.

(2) The board shall designate the chairman of the committee.

(3) The board may authorize the payment of remuneration and expenses to committee members in accordance with those rates prescribed by the board.

(4) A member of a committee shall be appointed for a term of one year and may be reappointed for further terms of one year each.

4 A committee shall

(a) advise the board

(i) on the planning, implementation and operation of the program,

(ii) respecting the development of policies, standards and guidelines for the program,

(iii) respecting the program budget, and

(iv) at the request of the board, on any other matters relating to the program,

(b) review the standards, policies and operating guidelines of the program,

(c) monitor and evaluate the performance of the program and the quality of care provided by the program, and

(d) make a report at least once in every 12 months to the board in such a manner as the board may direct.

5(1) A committee shall meet at least once every 2 months.

(2) A committee may, with the approval of the board, make rules governing

(a) the calling of its meetings,

(b) the conduct of its meetings, and

(c) any other matters pertaining to the conduct of its business and affairs.

6 In order to provide a program in accordance with section 2(1), a board shall appoint, as a member of the board's staff, at least one co-ordinator who shall

(a) conduct all assessments of patients for admission to the program,

(b) admit patients who satisfy the requirements of section 7 to the program,

(c) monitor, re-assess and discharge patients admitted to the program,

(d) determine, within the budget of the board, the level and type of home care services to be provided to persons admitted to the program, and

(e) subject to section 11, determine the amount of any fee to be paid by a patient for any non-medical services provided by the program.

7(1) Where

(a) a physician certifies that, in his opinion, a person under his care is in need of a home care nursing or rehabilitation therapy service, and

(b) a co-ordinator certifies that, in his opinion

(i) a person's home is suitable for the provision of the program,

(ii) a person requires home care nursing or rehabilitation therapy service,

(iii) due to a person's condition, the program is the most suitable method of providing health services,

(iv) a person is registered under the Alberta Health Care Insurance Plan, and

(v) the cost of providing home care services to a person will not exceed the cost of providing the equivalent level of care in a health care facility,

that person may be admitted to the program.

(2) A person who has been refused admission to a program by a co-ordinator under clause (b), may apply to the board for a review of that decision and the board may confirm, reverse or vary the decision of the co-ordinator.

(3) In reviewing the decision of the co-ordinator under subsection (2), the board shall use the criteria referred to in subsection (1)(b).

8 Where the co-ordinator certifies that a person who is admitted to the program requires

(a) home nursing services, or

(b) homemaker or home help services,

(c) physiotherapy, speech therapy, occupational therapy, respiratory therapy, dressings, drugs, biologicals or other related preparations, or the use of any of the medical equipment listed in Schedule 1, or

(d) handyman services, meals on wheels, wheels to meals, or transportation services,

the board may, out of grants provided by the Minister for the purpose, provide that service to that person.

9(1) A board shall submit to the Minister, in a form prescribed by the Minister, reports respecting the operation of the program.

(2) A co-ordinator shall keep a record, in a form prescribed by the Minister, respecting each person admitted to the program and that record shall include a case plan for each such person.

(3) Information obtained from records maintained by the co-ordinator in accordance with subsection (2) shall be treated as confidential information and shall not be published, released or disclosed in any manner that would be detrimental to the personal interests, reputation or privacy of the person who is the subject of the record.

(4) Notwithstanding subsection (3), the co-ordinator may disclose any diagnosis, record or any information relating to a person admitted to the program:

(a) to the person to whom the diagnosis, record or information relates or his legal representative,

(b) to a board or an agent of a board or a physician or a department or agency of the Government where that board or agent or physician or department or agency is responsible for providing continued treatment to the person to whom the diagnosis, record of information relates,

(c) to a department or agency of the Government when the disclosure is necessary in the administration of the Act, or in the best interests of the person to whom the diagnosis, record or information relates,

(d) to a person conducting bona fide research or medical review if the disclosure is made in such a manner as to ensure confidentiality of the diagnosis, record or information,

(e) to the Director of Medical Services appointed under The Occupational Health and Safety Act where the diagnosis, record or information relates to an accident that occurred in respect of the person's occupation or one or more of his former occupations,

(f) to a Workers' Compensation Board, the Alberta Hospital Association, the Department of Social Services and Community Health, or a provincial hospital insurance authority or the Department of Veterans' Affairs if the information is required in order to establish liability for payment,

(g) to the Department of National Health and Welfare for purposes in connection with the Hospital Insurance and Diagnostic Services Act (Canada), or

(h) to a professional disciplinary body established under any Act of the Legislature where

> (i) an officer of the body makes a written request for the information and the disclosure is consented to by the person to whom the diagnosis, record or information relates or his legal representative, or
>
> (ii) the disclosure is made in compliance with the legal notice issued pursuant to an Act of Legislature requiring the attendance of a witness or the production of documents.

10 Where a person admitted to a program is eligible to receive reimbursement for a service mentioned in section 8 under

(a) the Extended Health Care Benefits Program,

(b) the Veterans' Affairs Act (Canada),

(c) the Blue Cross Plan, except for home nursing care,

(d) the General Services Medical Insurance Plan,

(e) Workers' Compensation, or

(f) any private insurance program

that person shall reimburse the board for the cost of the health service provided under the program to the extent that the person is eligible for reimbursement from one or more of the bodies mentioned in clauses (a) to (f).

11(1) Services mentioned in section 8(c) and home nursing services mentioned in section 8(a) shall be provided without charge to persons admitted to the program.

(2) Support services shall be provided without charge to persons admitted to the program for the first 2 weeks after the date of admission of that person to the program but that person shall not be eligible again for support services without charge until after the expiration of 180 days from the date of his last discharge from the program.

(3) A person receiving support services listed in Schedule 2 after the expiration of the 2 week period mentioned in subsection (2) shall be charged a monthly user fee and that fee shall be the lesser of

(a) the actual cost of the service provided per month, or

(b) the monthly amount determined by the co-ordinator in accordance with section 12 and Schedule 3.

12(1) For the purposes of this section "family" includes

(a) the patient admitted to the program,

(b) any person living in the same household as the patient who is financially dependent upon or responsible for the patient, including unmarried children of the patient under the age of 18 years but excluding children of the patient who are over the age of 18 years and financially independent of the patient, and

(c) the parents of the patient where they live in the same household as the patient.

(2) In determining the monthly amount of the user fee under section 11(3)(b), the co-ordinator shall determine the net monthly income of the family and to determine that income shall include all family income from

(a) employment

(b) unemployment insurance,

(c) worker's compensation

(d) adult training allowances, bursaries, fellowships or scholarships,

(e) pension payments,

(f) disability insurance payments,

(g) old age security payments,

(h) the guaranteed income supplement,

(i) senior citizens' benefits,

(j) family allowances,

(k) alimony and maintenance payments,

(l) social allowances,

(m) interest payments,

(n) mortgage or rental payments,

(o) investments, and

(p) any other regular income from any federal or provincial government agency.

13 The Minister may review the operation of any program and for that purpose may require that the board provide him with any information he considers necessary.

14 Notwithstanding section 2, where a board has prior to the effective date of this regulation received grants from the Minister for the purpose of providing a home care program, that board shall, on and from July 1st, 1978 provide that program in accordance with this regulation.

APPENDIX B

INTERVIEW QUESTIONS

B.1 Home Care Programs

REVIEW OF THE ALBERTA COORDINATED HOME CARE PROGRAM

GENERAL QUESTIONNAIRE*

The following questions will be used by RMC as guidelines for discussions. In no way are they meant to preclude discussion on other topics or issues related to Home Care which the interviewees may raise.

1. What has been your involvement with the Coordinated Home Care Program?
2. What is your perception of the purpose of the CHCP?
3. What have been the achievements/accomplishments of the program since its introduction to your area?
4. Are the people in this area obtaining the services they need from the Home Care Program?
5. Are there any special service needs in your area related to Home Care that may arise in the future?
6. How should the Home Care Program respond to these future needs?
7. What do you see as the greatest STRENGTHS of the CHCP?
8. What do you see as the greatest WEAKNESSES OF THE CHCP?
9. How could the weaknesses be remedied?
10. Other comments?

* For interviews with representatives of Health Unit Boards, Home Care Management Committees, Administration, Staff and Providers.

B.2 Submissions

REVIEW OF THE ALBERTA COORDINATED HOME CARE PROGRAM

ASSOCIATIONS/GROUPS - QUESTIONNAIRE

The following questions may be helpful in preparing briefs, letters or other written submissions. In no way are they meant to preclude other topics or issues related to Home Care which associations/groups may wish to raise. If appropriate, associations/groups could advise their membership to send letters directly to RMC as added input.

1. What has been your involvement with the Alberta Coordinated Home Care Program (ACHCP)?
2. What is your perception of the purpose of the ACHCP?
3. What have been the achievements/accomplishments of the program since its introduction?
4. Are the people of Alberta obtaining the services they need from Home Care Programs?
5. Are there any special service needs related to Home Care that may arise in the future?
6. How should the Home Care Program respond to these future needs?
7. What do you see as the greatest STRENGTHS OF THE ACHCP?
8. What do you see as the greatest WEAKNESSES OF THE ACHCP?
9. How could the weaknesses be remedied?
10. Other special issues related to Home Care and your association's role.

NOTE: Requests for confidentiality will be honoured by RMC.

Time Frame: Briefs, letters etc. are requested by December 17, 1982. Otherwise RMC cannot guarantee incorporation of input into final report.

Mailing Address:
RMC Resources Management Consultants (Alberta) Ltd.
10443-85 Ave.
Edmonton, Alberta
T6E 2K2

Attention: Alberta Coordinated Home Care Review Project

B.3 Clients

REVIEW OF THE ALBERTA COORDINATED HOME CARE PROGRAM

CLIENT QUESTIONNAIRE

The following questions will be used by the interviewer as guidelines for discussion with clients. Comments on any other topics or issues related to Home Care will be welcomed.

1. Could you explain your involvement with the Coordinated Home Care Program?

2. Has the program been helpful to you?
   If so, in what way?
   If not, why not?

3. How could it be more helpful?

B.4 Sample Public Meeting Handout

REVIEW OF THE ALBERTA COORDINATED HOME CARE PROGRAM

Public Meeting: Medicine Hat

Date & Time: December 6, 1982, 7:30 p.m.

Place: Veiner Centre
225 - Woodman Ave.
Medicine Hat, Alberta

Members of RMC Team conducting study are: Myroslaw Kohut
Lynne Mansell

Purpose of Meeting: The purpose of the public meeting is to provide opportunity for you to present your views in how well the program is doing.

The following questions can be used as guidelines for the discussion. In no way are they meant to preclude discussion on other topics or issues related to Home Care that you care to raise:

1. What have been the achievements/accomplishments of the Coordinated Home Care Program since its introduction to your area?
2. Is the present program reaching those people in your area who require it?
3. Are there any special service needs in your area related to Home Care that may arise in the future?
4. How should the Home Care Program respond to these future needs?
5. What do you see as the greatest STRENGTHS OF THE CHCP?
6. What do you see as the greatest WEAKNESSES OF THE CHCP?
7. Other comments?

If you would like to present your views in written form (letters or brief), please send to:

RMC Resources Management Consultants (Alberta) Ltd.
10443-85 Avenue
Edmonton, Alberta T6E 2K2
Tel. No. 432-0284

Attention: Alberta Home Care Review Project

Written submissions should be received by RMC before Christmas.

B.5 Assessment and Placement Committee Respresentatives

REVIEW OF THE ALBERTA COORDINATED HOME CARE PROGRAM

TELEPHONE INTERVIEW QUESTIONS

1. Is there a representative of the Coordinated Home Care Program on the Assessment & Placement Committee?

2. To your knowledge, is Home Care considered as an alternative to institutional placement?

3. In your opinion, has Home Care had any effect on the length of the waiting lists for auxiliary hospitals and nursing homes?

4. Other comments?

APPENDIX C

LISTS OF RESPONDENTS

C.1 Local Health Authorities

	Name	Location Type
1.	Alberta East Central	Rural
2.	Alberta West Central	Rural
3.	Athabasca	Rural
4.	Banff National Park	Rural
5.	Barons-Eureka-Warner	Rural
6.	Big Country	Rural
7.	Calgary Local Board of Health	Urban
8.	Chinook	Rural
9.	City of Lethbridge	Urban
10.	Drumheller	Rural
11.	Edmonton	Urban
12.	Foothills	Rural
13.	Fort McMurray and District	Urban
14.	Grande Prairie	Mixed
15.	Jasper National Park	Rural
16.	Leduc-Strathcona	Mixed
17.	Minburn-Vermilion	Rural
18.	Mount View Health Unit	Rural
19.	North Eastern Alberta	Rural
20.	Peace River	Rural
21.	Red Deer	Mixed
22.	Southeastern Alberta	Mixed
23.	Stony Plain-Lac Ste. Anne	Rural
24.	Sturgeon	Mixed
25.	Vegreville	Rural
26.	Wetoka	Rural

C.2 List of Submissions

ASSOCIATIONS - GENERAL

Alberta Committee of Consumer Groups of Disabled Persons
Multiple Sclerosis Society of Canada, Alberta Division
Multiple Sclerosis Society of Canada, Lloydminster Chapter
Multiple Sclerosis Society of Canada, Edmonton Chapter
Alberta Rehabilitation Council for the Disabled
Society for the Retired and Semi-Retired of Edmonton
Lethbridge Volunteer Bureau
Hospice Care Edmonton
The Alberta Registered Dietitians Association
Alberta Association of Registered Occupational Therapists
Alberta Association of Registered Nursing Assistants
Alberta Association of Registered Nursing Orderlies
Victorian Order of Nurses, Medicine Hat Branch
Victorian Order of Nurses, Lethbridge Branch
Independent Therapists Ltd.
Alberta Public Health Association
Friends of Medicare

ASSOCIATIONS - DESIGNATED FOR INTERVIEW

Victorian Order of Nurses, Province of Alberta
Alberta Association of Registered Nurses
Alberta Council on Aging
Provincial Senior Citizens Advisory Council
Alberta Association of Homemaker Services
Alberta Medical Association - Committee on Aging
Dr. Hyde, former Chairman Nursing Home Review Panel
Alberta Hospitals Association - Executive Director
Health Unit Association of Alberta - Executive Director

C.2 List of Submissions
(continued)

INSTITUTIONS

Senior Citizens Lodge, Legal
Pleasant View Lodge, Spirit River
Thorhild Lodge Senior Citizens Home
Radway Health Care Centre
Athabasca Municipal Hospital District No. 3
Two Hills General Hospital & Nursing Home District No. 42
High River Hospital & Nursing Home
Brooks Health Centre
Lethbridge General and Auxiliary Hospital and Nursing Home District No. 65
St. Michael's Hospital, Lethbridge
Medicine Hat & District Hospital
Foothills Hospital
Rockyview Hospital
The Salvation Army Grace Hospital, Calgary
Charles Camsell General Hospital
Cross Cancer Institute
Glenrose Hospital
Misericordia Hospital
University of Alberta Hospitals (2)
Royal Alexandra Hospitals

FAMILY & COMMUNITY SUPPORT SERVICES

Community Services Division, Medicine Hat
Family & Community Support Services, Grande Cache
Family and Community Services, Two Hills
Family & Community Support Services, St. Paul
Family and Community Support Services, Red Deer
Wolf Creek/Pembina Community Services, Wildwood
Family and Community Support Services Home Services, Viking
Family and Community Services, Strathcona
Family and Community Support Services, Provost and District
Family and Community Support Services, Lacombe and District
Camrose and District Support Services
Social Services Advisory Committee, Edmonton
Social Services Department, Calgary
Town of Whitecourt Homemaking Program

C.2 List of Submissions (continued)

INDIVIDUAL SUBMISSIONS

Margaret Massing, Ponoka
Mertin A. Collin, Lethbridge
Herbert and Ina Joudrie, Edmonton
Mrs. H. W. Short, Elnora Pioneer Club, Elnora (and 52 signature petition)
Anonymous (2)
Dr. C. V. Godberson, Barrhead Clinic, Barrhead
Dr. S. Mahalingham, Sivanathan Mahalingham Professional Corporation, Radway
Dick Varga, Coordinator, The University of Lethbridge, Lethbridge
Irm Dogterom, Lethbridge
Mrs. M. Gee, The University of Alberta, Edmonton - (and 37 signature petition)
Rev. Neil Lackey, Redwater Pastoral Charge
Stuart Donaldson M.Sc., Okotoks Professional Centre, Okotoks
Olga Buma, Meals-On-Wheels, St. Albert
Therese Ricard, Morinville
S. Wilson, R.N.
Ron Keller, M.D., Bentley Medical Clinic, Bentley
Drs. G. Bonham/P. Wilson/N. Bayliss
Dr. Sandy J. Murray, Red Deer

C.3 Public Meetings

Location Type	Location	Attendance
Rural	Athabasca	3
	Edson	20
	High River	35
	Redwater	22
	Vegreville #1	14
	Vegreville #2	8
	Wetaskiwin	12
	Subtotal	114
Urban(1)	Edmonton	22
	Fort McMurray	7
	Grande Prairie	4
	Lethbridge	50
	Medicine Hat	6
	Red Deer	20
	Subtotal	109
	TOTAL	223

(1) Attendance at the Calgary Home Care Workshop was 68.

C.4 Assessment and Placement Committee Representatives

Barrhead Nursing Home
Bethany Auxiliary, Camrose
Brooks Health Care Center
Calgary Auxiliary Hospital & Nursing Home District No. 7
Coronation - Paintearth Nursing Home, Coronation
Drumheller Auxiliary & Nursing Home
Eagle View Nursing Home, Two Hills
Edmonton & Rural Auxiliary Hospital and Nursing Home District No. 24
Fairview Nursing Home
Flagstaff Auxiliary, Killam
Grande Prairie Auxiliary Hospital & Nursing Home
Grandview Nursing Home, Cardston
High River Auxiliary and Nursing Home
Lacombe Nursing Home
Lamont Auxiliary Hospital
Lethbridge Regional Hospital
Lloydminster Auxiliary Hospital & Nursing Home
Medicine Hat & District Hospital (Auxiliary Center)
Mountain View - Kneehill Auxiliary, Didsbury
Our Lady of the Lake Nursing Home, McLennon
Peace River Auxiliary Hospital & Nursing Home
Provost Municipal Health Care Centre
Red Deer Regional Hospital Centre
Rimbey Auxiliary
Smoky Lake Nursing Home
Stettler Nursing Home
Vegreville Auxiliary
Vermilion Health Care Center
Wainwright & District Health Care Complex
Westlock Nursing Home
Wetaskiwin Auxiliary
Willow Creek - Claresholm Auxiliary, Claresholm

APPENDIX D

HOME CARE PROGRAM INTERVIEW RESPONSES

HOME CARE PROGRAM INTERVIEW RESPONSE

Question 2. - Purpose

1. To enable the elderly to remain in their homes and community
2. To enable people to remain in their own homes
3. To provide services in the home
4. To promote/maintain independence
5. To improve/maintain quality of life
6. To reduce health care costs
7. To facilitate early discharge from acute care hospitals
8. To allow terminally ill patients to die at home
9. To support/assist families of clients
10. To reduce or prevent institutionalization/hospitalization
11. To free acute care hospital beds
12. To provide alternatives to institutional care
13. To coordinate required services
14. No response
15. Other(s)

Question 3. - Achievements

1. Allowed people to remain in their homes and community
2. Prevented/reduced institutionalization
3. Allowed some elderly to remain in own home and community
4. Freed acute care hospital beds
5. Allowed earlier discharge from hospitals
6. Improved client's quality of life
7. Promoted independence
8. Allowed many terminally ill persons to die at home
9. Involved family members
10. Saved health care dollars/cost effectiveness
11. Expanded profile of Health Unit
12. Client/community satisfied
13. Increased physician awareness and support
14. Coordination of services/efficiency
15. Expanded access to support services in community
16. Expanded access to rehab. services in community
17. Expansion of caseload/program
18. Covered large geographic area
19. Allowed people to remain in Lodges
20. Met needs of people at local level
21. Provided ADL aids, equipment
22. No response
23. Other(s)

Question 4. - Are People Receiving Services Needed

1. Yes/Yes generally (unqualified)
2. Don't know/No response
3. Not those without medical entry
4. Not those in rural or outlying areas/inconsistent coverage
5. Not those without an AHCIP number
6. Not those who are unaware of the program
7. Not those who are not referred
8. Not Treaty Indians on reserves
9. Not handicapped children and young adults
10. No, insufficient support services
11. No, insufficient rehab. services
12. No, insufficient physiotherapy
13. No, insufficient occupational therapy
14. Not those needing mental health services
15. No, insufficient services due to budget restraints
16. Other(s)

Question 5. - Future Service Needs & Impacts

1. Expanded services for the elderly
2. Increased level of existing services
3. No changes (or few) expected from current caseload or level of service
4. New or expanded palliative care program
5. Early maternity discharge program
6. Early discharge program
7. Expanded support services/social entry
8. Expanded rehab. services
9. Mental health services
10. None
11. No response
12. Other(s)

Question 6. - Responses to Future Needs

1. Increase funding/staffing
2. Broaden/change entry criteria
3. Joint planning (agency, gov't levels)
4. Local planning and coordination
5. Expand training/education
6. Change budget base/process
7. Expand Home Care Program/add required services
8. Develop volunteer services (further)
9. No response
10. Other(s)

Question 7. - Strengths

1. Qualities of staff (committed, caring)
2. Team approach/internal communication
3. Coordination/cooperation of resources/agencies
4. Physician support, cooperation
5. Family involvement, support
6. Volunteer involvement, support
7. Home Care Management Committees/subcommittees input, support
8. Keeps people at home
9. Flexibility of program to adapt to individual needs
10. Community based/in Health Unit
11. Good liaison with hospitals
12. Cost-effectiveness
13. Provides needed services
14. Client control/independence/choice/quality of life
15. None
16. No response
17. Other(s)

RMC

8. Weaknesses

1. Lack of social/restrictiveness of medical entry criteria
2. Lack of FCSS program in some parts of Health Unit
3. Insufficient support services in Home Care Program (incl. volunteers)
4. Paperwork volume, complexity/info. system deficiencies
5. Lack of public awareness/insufficient public relations
6. Lack of physician awareness/involvement
7. Reluctance of physicians to refer to Home Care/no compensation
8. Poor hospital liaison planning
9. Restriction of eligibility to those with AHCIP number
10. Insufficient funding to meet existing service requirements
11. Insufficient funding for growth/expansion
12. Insufficient funding to complete implementation
13. Home Care budget as part of Health Unit budget (global)
14. Fee schedule problems
15. Role conflict between Home Care and Community Health programs within the Health Unit
16. Lack of clarity/purpose in the role of the Home Care Management Committee
17. Inadequate communications, coordination or conflict among agencies involved in Home Care
18. Jurisdictional issues/lack of coordination between government departments affecting the Home Care Program
19. Lack of agreement regarding the role/composition of the Home Care Unit (Directorate)
20. Lack of incentive to utilize Home Care rather than acute hospital care
21. No weaknesses
22. No response
23. Other(s)

Question 9. - Remedies

1. Increase public awareness and education
2. Increase physician awareness and education
3. Improve hospital discharge planning, involvement HC
4. Increase funding/staffing
5. Broaden entry - social/functional
6. No social entry - other agencies should be responsible
7. Social entry only where FCSS
8. Fund HC separately from Health Unit
9. Change budget process to reflect local conditions
10. Standardize support services user fees with FCSS
11. Establish flat user fees
12. Eliminate user fees
13. Provide financial compensation for physician's services
14. Clarify role/mandate of Home Care Management Committee
15. Make Home Care Managment Committees optional
16. Eliminate requirement for AHCIP number
17. Streamline information system/paperwork
18. No response
19. Other(s)

APPENDIX A

HOME CARE PROGRAM REGULATIONS

THE HEALTH UNIT ACT

Home Care Program Regulation

1 In this regulation,

(a) "Act" means The Health Unit Act;

(b) "board" means the board of a health unit appointed under the Act and includes a local board of health;

(c) "committee" means a home care management committee established under section 3;

(d) "co-ordinator" means a home care program co-ordinator appointed under section 6;

(e) "home help service" means routine housecleaning, laundry, ironing and meal preparation;

(f) "homemaker service" means the service provided by a homemaker and includes

(i) personal hygiene care and assistance with activities of daily living,

(ii) household management, marketing, meal preparation, house cleaning and laundry,

(iii) child care during the absence or incapacity of a parent,

(iv) emotional support,

(v) teaching child care, care of the ill and household management, and

(vi) activities delegated to the homemaker by a homecare nurse or rehabilitation therapist and that are supervised by a health professional;

(g) "program" means the home care program;

(h) "support services" include homemaker service, home help service, handyman service, meals on wheels, wheels to meals and transportation.

2(1) A board may submit a home care program to the Minister for approval and if that program is approved, the board shall, out of grants provided by the Minister for the purpose, provide the program in accordance with this regulation.

(2) The program shall provide home care services and the board shall co-ordinate with other agencies providing similar health and support services.

(3) A home care program shall include

(a) home nursing services, and

(b) homemaker or homehelp services.

(4) A home care program may include

(a) physiotherapy, speech therapy, occupational therapy, respiratory therapy, dressings, drugs, biologicals or other related preparations, or the use of any of the medical equipment listed in Schedule 1, or

(b) handyman services, meals on wheels, wheels to meals, or transportation services.

(5) The board shall, in providing a program, utilize volunteer services to the fullest extent possible.

3(1) In order to provide a program in accordance with section 2(1), a board shall establish at least one committee and shall appoint to each committee

(a) one person representing the hospital, auxiliary and nursing home districts and hospital boards within the board's health unit or health district, as the case may be,

(b) one person representing the preventive social services boards within the board's health unit or health district, as the case may be,

(c) at least one person representing the board,

(d) a physician engaged in private practice within the board's health unit or health district, as the case may be, and

(e) not more than 7 persons, who are either providers or consumers of home care services, or citizens at large, residing within the board's health unit or health district, as the case may be, and participating in the program.

(2) The board shall designate the chairman of the committee.

(3) The board may authorize the payment of remuneration and expenses to committee members in accordance with those rates prescribed by the board.

(4) A member of a committee shall be appointed for a term of one year and may be reappointed for further terms of one year each.

4 A committee shall

(a) advise the board

(i) on the planning, implementation and operation of the program,

(ii) respecting the development of policies, standards and guidelines for the program,

(iii) respecting the program budget, and

(iv) at the request of the board, on any other matters relating to the program,

(b) review the standards, policies and operating guidelines of the program,

(c) monitor and evaluate the performance of the program and the quality of care provided by the program, and

(d) make a report at least once in every 12 months to the board in such a manner as the board may direct.

5(1) A committee shall meet at least once every 2 months.

(2) A committee may, with the approval of the board, make rules governing

(a) the calling of its meetings,

(b) the conduct of its meetings, and

(c) any other matters pertaining to the conduct of its business and affairs.

6 In order to provide a program in accordance with section 2(1), a board shall appoint, as a member of the board's staff, at least one co-ordinator who shall

(a) conduct all assessments of patients for admission to the program,

(b) admit patients who satisfy the requirements of section 7 to the program,

(c) monitor, re-assess and discharge patients admitted to the program,

(d) determine, within the budget of the board, the level and type of home care services to be provided to persons admitted to the program, and

(e) subject to section 11, determine the amount of any fee to be paid by a patient for any non-medical services provided by the program.

7(1) Where

(a) a physician certifies that, in his opinion, a person under his care is in need of a home care nursing or rehabilitation therapy service, and

(b) a co-ordinator certifies that, in his opinion

(i) a person's home is suitable for the provision of the program,

(ii) a person requires home care nursing or rehabilitation therapy service,

(iii) due to a person's condition, the program is the most suitable method of providing health services,

(iv) a person is registered under the Alberta Health Care Insurance Plan, and

(v) the cost of providing home care services to a person will not exceed the cost of providing the equivalent level of care in a health care facility,

that person may be admitted to the program.

(2) A person who has been refused admission to a program by a co-ordinator under clause (b), may apply to the board for a review of that decision and the board may confirm, reverse or vary the decision of the co-ordinator.

(3) In reviewing the decision of the co-ordinator under subsection (2), the board shall use the criteria referred to in subsection (1)(b).

8 Where the co-ordinator certifies that a person who is admitted to the program requires

(a) home nursing services, or

(b) homemaker or home help services,

(c) physiotherapy, speech therapy, occupational therapy, respiratory therapy, dressings, drugs, biologicals or other related preparations, or the use of any of the medical equipment listed in Schedule 1, or

(d) handyman services, meals on wheels, wheels to meals, or transportation services,

the board may, out of grants provided by the Minister for the purpose, provide that service to that person.

9(1) A board shall submit to the Minister, in a form prescribed by the Minister, reports respecting the operation of the program.

(2) A co-ordinator shall keep a record, in a form prescribed by the Minister, respecting each person admitted to the program and that record shall include a case plan for each such person.

(3) Information obtained from records maintained by the co-ordinator in accordance with subsection (2) shall be treated as confidential information and shall not be published, released or disclosed in any manner that would be detrimental to the personal interests, reputation or privacy of the person who is the subject of the record.

(4) Notwithstanding subsection (3), the co-ordinator may disclose any diagnosis, record or any information relating to a person admitted to the program:

(a) to the person to whom the diagnosis, record or information relates or his legal representative,

(b) to a board or an agent of a board or a physician or a department or agency of the Government where that board or agent or physician or department or agency is responsible for providing continued treatment to the person to whom the diagnosis, record of information relates,

(c) to a department or agency of the Government when the disclosure is necessary in the administration of the Act, or in the best interests of the person to whom the diagnosis, record or information relates,

(d) to a person conducting bona fide research or medical review if the disclosure is made in such a manner as to ensure confidentiality of the diagnosis, record or information,

(e) to the Director of Medical Services appointed under The Occupational Health and Safety Act where the diagnosis, record or information relates to an accident that occurred in respect of the person's occupation or one or more of his former occupations,

(f) to a Workers' Compensation Board, the Alberta Hospital Association, the Department of Social Services and Community Health, or a provincial hospital insurance authority or the Department of Veterans' Affairs if the information is required in order to establish liability for payment,

(g) to the Department of National Health and Welfare for purposes in connection with the Hospital Insurance and Diagnostic Services Act (Canada), or

(h) to a professional disciplinary body established under any Act of the Legislature where

(i) an officer of the body makes a written request for the information and the disclosure is consented to by the person to whom the diagnosis, record or information relates or his legal representative, or

(ii) the disclosure is made in compliance with the legal notice issued pursuant to an Act of Legislature requiring the attendance of a witness or the production of documents.

10 Where a person admitted to a program is eligible to receive reimbursement for a service mentioned in section 8 under

(a) the Extended Health Care Benefits Program,

(b) the Veterans' Affairs Act (Canada),

(c) the Blue Cross Plan, except for home nursing care,

(d) the General Services Medical Insurance Plan,

(e) Workers' Compensation, or

(f) any private insurance program

that person shall reimburse the board for the cost of the health service provided under the program to the extent that the person is eligible for reimbursement from one or more of the bodies mentioned in clauses (a) to (f).

11(1) Services mentioned in section 8(c) and home nursing services mentioned in section 8(a) shall be provided without charge to persons admitted to the program.

(2) Support services shall be provided without charge to persons admitted to the program for the first 2 weeks after the date of admission of that person to the program but that person shall not be eligible again for support services without charge until after the expiration of 180 days from the date of his last discharge from the program.

(3) A person receiving support services listed in Schedule 2 after the expiration of the 2 week period mentioned in subsection (2) shall be charged a monthly user fee and that fee shall be the lesser of

(a) the actual cost of the service provided per month, or

(b) the monthly amount determined by the co-ordinator in accordance with section 12 and Schedule 3.

12(1) For the purposes of this section "family" includes

(a) the patient admitted to the program,

(b) any person living in the same household as the patient who is financially dependent upon or responsible for the patient, including unmarried children of the patient under the age of 18 years but excluding children of the patient who are over the age of 18 years and financially independent of the patient, and

(c) the parents of the patient where they live in the same household as the patient.

(2) In determining the monthly amount of the user fee under section 11(3)(b), the co-ordinator shall determine the net monthly income of the family and to determine that income shall include all family income from

(a) employment

(b) unemployment insurance,

(c) worker's compensation

(d) adult training allowances, bursaries, fellowships or scholarships,

(e) pension payments,

(f) disability insurance payments,

(g) old age security payments,

(h) the guaranteed income supplement,

(i) senior citizens' benefits,

(j) family allowances,

(k) alimony and maintenance payments,

(l) social allowances,

(m) interest payments,

(n) mortgage or rental payments,

(o) investments, and

(p) any other regular income from any federal or provincial government agency.

13 The Minister may review the operation of any program and for that purpose may require that the board provide him with any information he considers necessary.

14 Notwithstanding section 2, where a board has prior to the effective date of this regulation received grants from the Minister for the purpose of providing a home care program, that board shall, on and from July 1st, 1978 provide that program in accordance with this regulation.

APPENDIX B

INTERVIEW QUESTIONS

B.1 Home Care Programs

REVIEW OF THE ALBERTA COORDINATED HOME CARE PROGRAM

GENERAL QUESTIONNAIRE*

The following questions will be used by RMC as guidelines for discussions. In no way are they meant to preclude discussion on other topics or issues related to Home Care which the interviewees may raise.

1. What has been your involvement with the Coordinated Home Care Program?
2. What is your perception of the purpose of the CHCP?
3. What have been the achievements/accomplishments of the program since its introduction to your area?
4. Are the people in this area obtaining the services they need from the Home Care Program?
5. Are there any special service needs in your area related to Home Care that may arise in the future?
6. How should the Home Care Program respond to these future needs?
7. What do you see as the greatest STRENGTHS of the CHCP?
8. What do you see as the greatest WEAKNESSES OF THE CHCP?
9. How could the weaknesses be remedied?
10. Other comments?

* For interviews with representatives of Health Unit Boards, Home Care Management Committees, Administration, Staff and Providers.

B.2 Submissions

REVIEW OF THE ALBERTA COORDINATED HOME CARE PROGRAM

ASSOCIATIONS/GROUPS - QUESTIONNAIRE

The following questions may be helpful in preparing briefs, letters or other written submissions. In no way are they meant to preclude other topics or issues related to Home Care which associations/groups may wish to raise. If appropriate, associations/groups could advise their membership to send letters directly to RMC as added input.

1. What has been your involvement with the Alberta Coordinated Home Care Program (ACHCP)?
2. What is your perception of the purpose of the ACHCP?
3. What have been the achievements/accomplishments of the program since its introduction?
4. Are the people of Alberta obtaining the services they need from Home Care Programs?
5. Are there any special service needs related to Home Care that may arise in the future?
6. How should the Home Care Program respond to these future needs?
7. What do you see as the greatest STRENGTHS OF THE ACHCP?
8. What do you see as the greatest WEAKNESSES OF THE ACHCP?
9. How could the weaknesses be remedied?
10. Other special issues related to Home Care and your association's role.

NOTE: Requests for confidentiality will be honoured by RMC.

Time Frame: Briefs, letters etc. are requested by December 17, 1982. Otherwise RMC cannot guarantee incorporation of input into final report.

Mailing Address:
RMC Resources Management Consultants (Alberta) Ltd.
10443-85 Ave.
Edmonton, Alberta
T6E 2K2

Attention: Alberta Coordinated Home Care Review Project

B.3 Clients

REVIEW OF THE ALBERTA COORDINATED HOME CARE PROGRAM

CLIENT QUESTIONNAIRE

The following questions will be used by the interviewer as guidelines for discussion with clients. Comments on any other topics or issues related to Home Care will be welcomed.

1. Could you explain your involvement with the Coordinated Home Care Program?

2. Has the program been helpful to you?
   If so, in what way?
   If not, why not?

3. How could it be more helpful?

B.4 Sample Public Meeting Handout

REVIEW OF THE ALBERTA COORDINATED HOME CARE PROGRAM

Public Meeting: Medicine Hat

Date & Time: December 6, 1982, 7:30 p.m.

Place: Veiner Centre
225 - Woodman Ave.
Medicine Hat, Alberta

Members of RMC Team conducting study are: Myroslaw Kohut
Lynne Mansell

Purpose of Meeting: The purpose of the public meeting is to provide opportunity for you to present your views in how well the program is doing.

The following questions can be used as guidelines for the discussion. In no way are they meant to preclude discussion on other topics or issues related to Home Care that you care to raise:

1. What have been the achievements/accomplishments of the Coordinated Home Care Program since its introduction to your area?
2. Is the present program reaching those people in your area who require it?
3. Are there any special service needs in your area related to Home Care that may arise in the future?
4. How should the Home Care Program respond to these future needs?
5. What do you see as the greatest STRENGTHS OF THE CHCP?
6. What do you see as the greatest WEAKNESSES OF THE CHCP?
7. Other comments?

If you would like to present your views in written form (letters or brief), please send to:

RMC Resources Management Consultants (Alberta) Ltd.
10443-85 Avenue
Edmonton, Alberta T6E 2K2
Tel. No. 432-0284

Attention: Alberta Home Care Review Project

Written submissions should be received by RMC before Christmas.

B.5 Assessment and Placement Committee Respresentatives

REVIEW OF THE ALBERTA COORDINATED HOME CARE PROGRAM

TELEPHONE INTERVIEW QUESTIONS

1. Is there a representative of the Coordinated Home Care Program on the Assessment & Placement Committee?

2. To your knowledge, is Home Care considered as an alternative to institutional placement?

3. In your opinion, has Home Care had any effect on the length of the waiting lists for auxiliary hospitals and nursing homes?

4. Other comments?

APPENDIX C

LISTS OF RESPONDENTS

C.1 Local Health Authorities

	Name	Location Type
1.	Alberta East Central	Rural
2.	Alberta West Central	Rural
3.	Athabasca	Rural
4.	Banff National Park	Rural
5.	Barons-Eureka-Warner	Rural
6.	Big Country	Rural
7.	Calgary Local Board of Health	Urban
8.	Chinook	Rural
9.	City of Lethbridge	Urban
10.	Drumheller	Rural
11.	Edmonton	Urban
12.	Foothills	Rural
13.	Fort McMurray and District	Urban
14.	Grande Prairie	Mixed
15.	Jasper National Park	Rural
16.	Leduc-Strathcona	Mixed
17.	Minburn-Vermilion	Rural
18.	Mount View Health Unit	Rural
19.	North Eastern Alberta	Rural
20.	Peace River	Rural
21.	Red Deer	Mixed
22.	Southeastern Alberta	Mixed
23.	Stony Plain-Lac Ste. Anne	Rural
24.	Sturgeon	Mixed
25.	Vegreville	Rural
26.	Wetoka	Rural

C.2 List of Submissions

ASSOCIATIONS - GENERAL

Alberta Committee of Consumer Groups of Disabled Persons
Multiple Sclerosis Society of Canada, Alberta Division
Multiple Sclerosis Society of Canada, Lloydminster Chapter
Multiple Sclerosis Society of Canada, Edmonton Chapter
Alberta Rehabilitation Council for the Disabled
Society for the Retired and Semi-Retired of Edmonton
Lethbridge Volunteer Bureau
Hospice Care Edmonton
The Alberta Registered Dietitians Association
Alberta Association of Registered Occupational Therapists
Alberta Association of Registered Nursing Assistants
Alberta Association of Registered Nursing Orderlies
Victorian Order of Nurses, Medicine Hat Branch
Victorian Order of Nurses, Lethbridge Branch
Independent Therapists Ltd.
Alberta Public Health Association
Friends of Medicare

ASSOCIATIONS - DESIGNATED FOR INTERVIEW

Victorian Order of Nurses, Province of Alberta
Alberta Association of Registered Nurses
Alberta Council on Aging
Provincial Senior Citizens Advisory Council
Alberta Association of Homemaker Services
Alberta Medical Association - Committee on Aging
Dr. Hyde, former Chairman Nursing Home Review Panel
Alberta Hospitals Association - Executive Director
Health Unit Association of Alberta - Executive Director

C.2 List of Submissions (continued)

INSTITUTIONS

Senior Citizens Lodge, Legal
Pleasant View Lodge, Spirit River
Thorhild Lodge Senior Citizens Home
Radway Health Care Centre
Athabasca Municipal Hospital District No. 3
Two Hills General Hospital & Nursing Home District No. 42
High River Hospital & Nursing Home
Brooks Health Centre
Lethbridge General and Auxiliary Hospital and Nursing Home District No. 65
St. Michael's Hospital, Lethbridge
Medicine Hat & District Hospital
Foothills Hospital
Rockyview Hospital
The Salvation Army Grace Hospital, Calgary
Charles Camsell General Hospital
Cross Cancer Institute
Glenrose Hospital
Misericordia Hospital
University of Alberta Hospitals (2)
Royal Alexandra Hospitals

FAMILY & COMMUNITY SUPPORT SERVICES

Community Services Division, Medicine Hat
Family & Community Support Services, Grande Cache
Family and Community Services, Two Hills
Family & Community Support Services, St. Paul
Family and Community Support Services, Red Deer
Wolf Creek/Pembina Community Services, Wildwood
Family and Community Support Services Home Services, Viking
Family and Community Services, Strathcona
Family and Community Support Services, Provost and District
Family and Community Support Services, Lacombe and District
Camrose and District Support Services
Social Services Advisory Committee, Edmonton
Social Services Department, Calgary
Town of Whitecourt Homemaking Program

C.2 List of Submissions
(continued)

INDIVIDUAL SUBMISSIONS

Margaret Massing, Ponoka
Mertin A. Collin, Lethbridge
Herbert and Ina Joudrie, Edmonton
Mrs. H. W. Short, Elnora Pioneer Club, Elnora
(and 52 signature petition)
Anonymous (2)
Dr. C. V. Godberson, Barrhead Clinic, Barrhead
Dr. S. Mahalingham, Sivanathan Mahalingham Professional
Corporation, Radway
Dick Varga, Coordinator, The University of Lethbridge, Lethbridge
Irm Dogterom, Lethbridge
Mrs. M. Gee, The University of Alberta, Edmonton - (and
37 signature petition)
Rev. Neil Lackey, Redwater Pastoral Charge
Stuart Donaldson M.Sc., Okotoks Professional Centre, Okotoks
Olga Buma, Meals-On-Wheels, St. Albert
Therese Ricard, Morinville
S. Wilson, R.N.
Ron Keller, M.D., Bentley Medical Clinic, Bentley
Drs. G. Bonham/P. Wilson/N. Bayliss
Dr. Sandy J. Murray, Red Deer

C.3 Public Meetings

Location Type	Location	Attendance
Rural	Athabasca	3
	Edson	20
	High River	35
	Redwater	22
	Vegreville #1	14
	Vegreville #2	8
	Wetaskiwin	12
	Subtotal	114
Urban(1)	Edmonton	22
	Fort McMurray	7
	Grande Prairie	4
	Lethbridge	50
	Medicine Hat	6
	Red Deer	20
	Subtotal	109
	TOTAL	223

(1) Attendance at the Calgary Home Care Workshop was 68.

C.4 Assessment and Placement Committee Representatives

Barrhead Nursing Home
Bethany Auxiliary, Camrose
Brooks Health Care Center
Calgary Auxiliary Hospital & Nursing Home District No. 7
Coronation - Paintearth Nursing Home, Coronation
Drumheller Auxiliary & Nursing Home
Eagle View Nursing Home, Two Hills
Edmonton & Rural Auxiliary Hospital and Nursing Home District No. 24
Fairview Nursing Home
Flagstaff Auxiliary, Killam
Grande Prairie Auxiliary Hospital & Nursing Home
Grandview Nursing Home, Cardston
High River Auxiliary and Nursing Home
Lacombe Nursing Home
Lamont Auxiliary Hospital
Lethbridge Regional Hospital
Lloydminster Auxiliary Hospital & Nursing Home
Medicine Hat & District Hospital (Auxiliary Center)
Mountain View - Kneehill Auxiliary, Didsbury
Our Lady of the Lake Nursing Home, McLennon
Peace River Auxiliary Hospital & Nursing Home
Provost Municipal Health Care Centre
Red Deer Regional Hospital Centre
Rimbey Auxiliary
Smoky Lake Nursing Home
Stettler Nursing Home
Vegreville Auxiliary
Vermilion Health Care Center
Wainwright & District Health Care Complex
Westlock Nursing Home
Wetaskiwin Auxiliary
Willow Creek - Claresholm Auxiliary, Claresholm

APPENDIX D

HOME CARE PROGRAM INTERVIEW RESPONSES

HOME CARE PROGRAM INTERVIEW RESPONSE

Question 2. - Purpose

1. To enable the elderly to remain in their homes and community
2. To enable people to remain in their own homes
3. To provide services in the home
4. To promote/maintain independence
5. To improve/maintain quality of life
6. To reduce health care costs
7. To facilitate early discharge from acute care hospitals
8. To allow terminally ill patients to die at home
9. To support/assist families of clients
10. To reduce or prevent institutionalization/hospitalization
11. To free acute care hospital beds
12. To provide alternatives to institutional care
13. To coordinate required services
14. No response
15. Other(s)

Question 3. - Achievements

1. Allowed people to remain in their homes and community
2. Prevented/reduced institutionalization
3. Allowed some elderly to remain in own home and community
4. Freed acute care hospital beds
5. Allowed earlier discharge from hospitals
6. Improved client's quality of life
7. Promoted independence
8. Allowed many terminally ill persons to die at home
9. Involved family members
10. Saved health care dollars/cost effectiveness
11. Expanded profile of Health Unit
12. Client/community satisfied
13. Increased physician awareness and support
14. Coordination of services/efficiency
15. Expanded access to support services in community
16. Expanded access to rehab. services in community
17. Expansion of caseload/program
18. Covered large geographic area
19. Allowed people to remain in Lodges
20. Met needs of people at local level
21. Provided ADL aids, equipment
22. No response
23. Other(s)

Question 4. - Are People Receiving Services Needed

1. Yes/Yes generally (unqualified)
2. Don't know/No response
3. Not those without medical entry
4. Not those in rural or outlying areas/inconsistent coverage
5. Not those without an AHCIP number
6. Not those who are unaware of the program
7. Not those who are not referred
8. Not Treaty Indians on reserves
9. Not handicapped children and young adults
10. No, insufficient support services
11. No, insufficient rehab. services
12. No, insufficient physiotherapy
13. No, insufficient occupational therapy
14. Not those needing mental health services
15. No, insufficient services due to budget restraints
16. Other(s)

Question 5. - Future Service Needs & Impacts

1. Expanded services for the elderly
2. Increased level of existing services
3. No changes (or few) expected from current caseload or level of service
4. New or expanded palliative care program
5. Early maternity discharge program
6. Early discharge program
7. Expanded support services/social entry
8. Expanded rehab. services
9. Mental health services
10. None
11. No response
12. Other(s)

Question 6. - Responses to Future Needs

1. Increase funding/staffing
2. Broaden/change entry criteria
3. Joint planning (agency, gov't levels)
4. Local planning and coordination
5. Expand training/education
6. Change budget base/process
7. Expand Home Care Program/add required services
8. Develop volunteer services (further)
9. No response
10. Other(s)

Question 7. - Strengths

1. Qualities of staff (committed, caring)
2. Team approach/internal communication
3. Coordination/cooperation of resources/agencies
4. Physician support, cooperation
5. Family involvement, support
6. Volunteer involvement, support
7. Home Care Management Committees/subcommittees input, support
8. Keeps people at home
9. Flexibility of program to adapt to individual needs
10. Community based/in Health Unit
11. Good liaison with hospitals
12. Cost-effectiveness
13. Provides needed services
14. Client control/independence/choice/quality of life
15. None
16. No response
17. Other(s)

8. Weaknesses

1. Lack of social/restrictiveness of medical entry criteria
2. Lack of FCSS program in some parts of Health Unit
3. Insufficient support services in Home Care Program (incl. volunteers)
4. Paperwork volume, complexity/info. system deficiencies
5. Lack of public awareness/insufficient public relations
6. Lack of physician awareness/involvement
7. Reluctance of physicians to refer to Home Care/no compensation
8. Poor hospital liaison planning
9. Restriction of eligibility to those with AHCIP number
10. Insufficient funding to meet existing service requirements
11. Insufficient funding for growth/expansion
12. Insufficient funding to complete implementation
13. Home Care budget as part of Health Unit budget (global)
14. Fee schedule problems
15. Role conflict between Home Care and Community Health programs within the Health Unit
16. Lack of clarity/purpose in the role of the Home Care Management Committee
17. Inadequate communications, coordination or conflict among agencies involved in Home Care
18. Jurisdictional issues/lack of coordination between government departments affecting the Home Care Program
19. Lack of agreement regarding the role/composition of the Home Care Unit (Directorate)
20. Lack of incentive to utilize Home Care rather than acute hospital care
21. No weaknesses
22. No response
23. Other(s)